HCA Management Services

Group Contract

G-44028-TN-1

Prudential

PRU 77212-000458-000001

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

751 Broad Street
Newark, New Jersey 07102

Group Insurance Contract

Contract Holder: HCA MANAGEMENT SERVICES, LP ON BEHALF OF THE PLAN ADMINISTRATION COMMITTEE

Group Contract No.: G-44028-TN-1

Prudential will provide or pay the benefits described in the Group Insurance Certificate(s) listed in the Schedule of Plans of the Group Contract, subject to the Group Contract's terms. This promise is based on the Contract Holder's application and payment of the required premiums.

All of the provisions of the Group Insurance Certificate(s), attached to and made a part of the Group Contract, apply to the Group Contract as if fully set forth in the Group Contract.

The Group Contract takes effect on the Contract Date, if it is duly attested under the Group Contract Schedule. It continues as long as the required premiums are paid, unless it ends as described in its General Rules.

The Group Contract is non-participating. This means that it will not share in Prudential's profits or surplus earnings, and Prudential will pay no dividends on it.

The Group Contract is delivered in and is governed by the laws of the Governing Jurisdiction.

Margaret M. Foran

Secretary

Chief Executive Officer

Group Short and Long Term Disability Coverages

Group Contract Schedule

Contract Date: January 1, 2007 and restated as of January 1, 2009

Contract Anniversaries: January 1 of each year, beginning in 2010.

Premium Due Dates: The Contract Date, and the first day of the month beginning with February.

Governing Jurisdiction: State of Tennessee

Associated Companies: Associated Companies are employers who are the Contract Holder's subsidiaries or affiliates and are reported to Prudential in writing for inclusion under the Group Contract, provided that Prudential has approved such request.

Minimum Participation Number: 25

INCLUDED EMPLOYERS

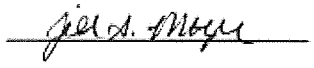
Included Employers under the Group Contract are the Contract Holder and its Associated Companies, if any.

An Employee of more than one Included Employer will be considered an Employee of only one of those employers for the purpose of the Group Contract. That Employee's service with all other Included Employers will be treated as service with that one.

On any date when an employer ceases to be an Included Employer, the Group Contract will be considered to end for Employees of that employer. This applies to all of those Employees except those who, on the next day, are still within the Covered Classes of a plan of benefits of the Group Contract as Employees of another Included Employer. The plans of benefits for Covered Classes are listed in the Group Contract's Schedule of Plans.

The Contract Holder must let Prudential know, in writing, when an employer listed as an Associated Company is no longer one of its subsidiaries or affiliates.

Table of Contents (as of the Contract Date): The Group Contract includes these forms with an 83500 prefix: COV 5010, GCS 1027, SPR 1001, GR 5075, SCH 1001, APP 1001.

Attest: 

Schedule of Premium Rates

G-44028-TN-1

Short Term Disability Coverage

Classes of Employees to which this Schedule applies:

For all active Full-time and Part-time employees who earn $6,000 or more annually

Applicable Coverage	**Monthly Rate Per Employee**
Short Term Disability Coverage	

Applicable Coverage	**Employee Insurance**
Short Term Disability Coverage	

Age Classification	**Monthly Rate per $100 of weekly benefit**
Less than 55	$19.62
55-59	$24.288
60-99	$36.852

Long Term Disability Coverage

Classes of Employees to which this Schedule applies:

For all active Full-time benefit-eligible Employees regularly scheduled to work at least 32 hours per week.

Long Term Disability Coverage

50% Benefit Option

Age Classification	Monthly Rate/$100
< 35	$0.104
35-39	$0.134
40-44	$0.219
45-49	$0.394
50-54	$0.559
55-59	$0.883
60+	$0.778

60% Benefit Option

Age Classification	Monthly Rate/$100
< 35	$0.142
35-39	$0.192
40-44	$0.300
45-49	$0.541
50-54	$0.776
55-59	$1.180
60+	$1.073

PERFORMANCE LEVELS

Prudential and the Contract Holder shall, from time to time, establish the performance service levels for each of the services to be measured, which may include, without limitation, standards for plan administration, customer service, phone service and abandonment rates, and timeliness of enrollment, underwriting and claim transactions. Prudential and the Contract Holder shall mutually agree upon a process for determining whether such performance levels have been met and the amount of any such credit that shall be made as a result of failure to meet such performance levels. Unless Prudential and the Contract Holder mutually agree to another process or timeline, a review of Prudential's performance will be done at the end of each calendar year and any applicable credit will be made on a date determined by Prudential and the Contract Holder.

Any amounts so credited shall be paid directly by check to the Contract Holder or to a trustee or other party at the Contract Holder's direction or, at the option of the Contract Holder shall be held by Prudential in an advance premium account and used to adjust premium for future billing periods.

To the extent any portion of the amounts credited or paid to the Contract Holder is required by law (including the Employee Retirement Income Security Act of 1974, as amended) to be used or applied solely for the benefit of Employees covered under this Group Contract, the Contract Holder agrees to use or apply such portion solely for the benefit of such Employees and to otherwise comply with any of its obligations under ERISA or other applicable law. Any funds accumulated in an advance premium account but unused as of the termination of the Group Contract, or any credited amounts otherwise due and unpaid, shall be transferred to the Contract Holder or to a trustee or other party at the Contract Holder's direction for use in connection with the Contract Holder's health and welfare programs. Upon transfer, Prudential shall have no responsibility for the use and/or allocation of any such funds, nor shall Prudential have any continuing obligations under this provision relating to performance levels. This provision does not create any third party beneficiary rights in any insured or other person.

General Rules

A. PAYMENT OF PREMIUMS - GRACE PERIOD.

Premiums are to be paid by the Contract Holder to Prudential. Each may be paid at a Prudential office or to one of its authorized agents. One is due on each Premium Due Date stated in the Group Contract Schedule. The Contract Holder may pay each premium other than the first within 60 days of the Premium Due Date without being charged interest. Those days are known as the grace period. The Contract Holder is liable to pay premiums to Prudential for the time the Group Contract is in force.

B. PREMIUM AMOUNTS.

The premium due on each Premium Due Date is the sum of the premium charges for the insurance under the Coverages. Those charges are determined from the premium rates then in effect and the Employees then insured.

The following will apply if one or more premiums paid include premium charges for an Employee whose insurance has ended before the due date of that premium. Prudential will not have to refund more than the amount of the premium charges for such Employee that were included in the premiums paid for the two months plus the current month immediately before the date Prudential receives written notice from the Contract Holder that the Employee's insurance has ended.

Premiums may be determined in another way. But it must produce about the same amounts and be agreed to by the Contract Holder and Prudential.

No premium charge will be made for an insured Employee under the Employee Long Term Disability Coverage while the Employee:

(1) is Disabled; and

(2) is entitled, after the Elimination Period, to benefits under the Coverage.

C. PREMIUM RATE CHANGES.

The premium rates in effect on the Contract Date are shown in the Group Contract's Schedule of Premium Rates. Prudential has the right to change premium rates:

(1) As of any Premium Due Date; and

(2) As of any date the extent or nature of the risk assumed is changed for any reason, including the reasons shown below:

    (a) With respect to the Short Term Disability Coverage, a 15% or more change in the number of covered lives or volume. *

    *Any rate change due to a 15% or more increase or decrease in the number of covered lives or volume will be effective on the next January 1 following the October annual enrollment. The base line for the first Contract Year and each Contract Year thereafter is the 2006 enrollment number of covered employees.

*Prudential will provide the Contract Holder with notice of any rate change due to a 15% or more increase or decrease in the number of covered lives or volume at least 4 months before the October annual enrollment.

(b) With respect to the Short Term Disability Coverage, the 15% change in the number of covered lives or volume does not apply to any spin offs or divestitures of the Contract Holder's facilities. But, it does apply if a division, subsidiary or associated company is added which results in an increase of 15% or more in the number of lives or volume.

(c) With respect to the Long Term Disability Coverage, a 25% or more change in the number of covered lives or volume.**

**Any rate change due to a 25% or more increase or decrease in the number of covered lives or volume will be effective on the next January 1 following the October annual enrollment. The base line for the first Contract Year and each Contract Year thereafter is the 2009 enrollment number of covered employees.

**Prudential will provide the Contract Holder with notice of any rate change due to a 25% or more increase or decrease in the number of covered lives or volume at least 4 months before the October annual enrollment.

(d) A significant change occurs in the plan design.

(e) A new law or a change in any existing law is enacted which applies to this plan.

But, unless the Schedule of Premuim Rates or an amendment states otherwise, (1) above will not be used to change premium rates:

- for Short Term Disability Coverage, within 36 months of the Contract Date.
- for Long Term Disability Coverage, within 48 months of the effective date of the Long Term Disability Coverage.

Prudential will notify the Contract Holder in writing at least 30 days before a premium rate is changed, except as noted in 2(a) and 2(c) above.

D. END OF THE GROUP CONTRACT OR OF AN INSURANCE.

During or at End of Grace Period - Failure to Pay Premiums: If any premium is not paid by the end of its grace period, the Group Contract will end when the grace period ends. The Contract Holder may write to Prudential, in advance, to ask that the Group Contract be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then the Group Contract will end on the date requested, but in no event will it end before the date Prudential receives the written request from the Contract Holder.

On a Premium Due Date - Failure to Maintain Insuring Conditions: On any Premium Due Date, Prudential may end the part of the Group Contract for Contributory or Non-contributory Employee Insurance or Dependents Insurance under a Coverage if one or more of the following conditions then exists for that part. But notice of its intent to do so must be given to the Contract Holder at least 120 days in advance.

Contributory Insurance: The insured Employees are:

(1) less than the Minimum Participation Number; or

(2) contributing at a rate higher than the maximum, if any, stated in the Group Contract for the insurance.

Non-contributory Insurance: The insured Employees are:

(1) less than the Minimum Participation Number; or

(2) contributing for the insurance.

The Minimum Participation Number is shown in the Group Contract Schedule.

On a Contract Anniversary: Prudential may end the Group Contract on any Contract Anniversary. But notice of its intent to do so must be given to the Contract Holder at least 120 days in advance.

E. AGE ADJUSTMENT.

If an Employee's age is used to determine the premium charge for an Employee's insurance and the age is found to be in error, the amount of the Employee's insurance under any Coverage affected by the change in age will then be adjusted to reflect the amount that the premium paid would have provided at the correct age. The Employer's age used to determine the premium charge is the Employee's age on January 1 for the entire Calendar Year.

F. EMPLOYEE'S CERTIFICATE.

Prudential will give the Contract Holder an individual certificate to give each insured Employee by electronic means. It will describe the Employee's coverage under the Group Contract. It will include (1) to whom Prudential pays benefits, (2) any protection and rights when the insurance ends, and (3) claim rights and requirements.

G. RECORDS - INFORMATION TO BE FURNISHED.

Either the Contract Holder or Prudential, as they agree, will keep a record of the insured Employees. It will contain the key facts about their insurance.

At the times set by Prudential, the Contract Holder will send the data required by Prudential to perform its duties under the Group Contract, and to determine the premium rates. All records of the Contract Holder which bear on the insurance must be open to Prudential for its inspection at any reasonable time.

Prudential will not have to perform any duty that depends on such data before it is received in a form that satisfies Prudential. The Contract Holder may correct wrong data given to Prudential, if Prudential has not been harmed by acting on it. An Employee's insurance under a Coverage will not be made invalid by failure of the Contract Holder or the Employer, due to clerical error, to record or report the Employee for that insurance.

H. THE CONTRACT - INCONTESTABILITY OF THE CONTRACT.

The entire Group Contract consists of: (1) the Group Insurance Certificate(s) listed in the Schedule of Plans, a copy of which is attached to the Group Contract; (2) all modifications and endorsements to such Group Insurance Certificates which are attached to and made a part of the Group Contract by amendment to the Group Contract; (3) the forms shown in the Table of Contents as of the Contract Date; (4) the Contract Holder's application, a copy of which is attached to the Group Contract; (5) any endorsements or amendments to the Group Contract; and (6) the individual applications, if any, of the persons insured.

No statement of the Contract Holder will be used in any contest of the insurance under the Group Contract.

There will be no contest of the validity of the Group Contract, except for not paying premiums, after it has been in force for one year.

I. MODIFICATION OF THE GROUP CONTRACT.

The Group Contract may be amended, at any time, without the consent of the insured Employees or of anyone else with a beneficial interest in it. This can be done through written request made by the Contract Holder and agreed to by Prudential. But an amendment will not affect a claim incurred before the date of change.

Only an officer of Prudential has authority: to waive any conditions or restrictions of the Group Contract; or to extend the time in which a premium may be paid; or to make or change a contract; or to bind Prudential by a promise or representation or by information given or received. A Prudential agent is not an officer.

No change in the Group Contract is valid unless shown in:

(1) an endorsement on it signed by an officer of Prudential; or

(2) an amendment to it signed by the Contract Holder and by an officer of Prudential.

But, a change in the Group Contract may be made in an amendment to it that is signed only by an officer of Prudential if:

(1) The amendment reflects a change in the Group Contract that has been automatically made to satisfy the requirements of any state or federal law or regulation that applies to the Group Contract, as provided in the Conformity With Law section. This change is known as a Statutory Amendment.

(2) The amendment reflects a change in Prudential's administration of its group insurance benefits and is intended to apply to all group insurance contracts which are affected by the change. This change is known as a Portfolio Amendment. Prudential will give the Contract Holder written notice of its intent to make a Portfolio Amendment in the Group Contract at least 180 days in advance of the effective date of the Amendment. When the Group Contract is so amended, payment by the Contract Holder of the next premium due under the Group Contract will constitute acceptance of the Portfolio Amendment, unless the Contract Holder has rejected the Amendment, in writing, prior to its effective date.

J. OTHER GOODS AND SERVICES.

From time to time, only upon prior written consent by the Contract Holder, Prudential may offer or provide Covered Persons or their Beneficiaries certain goods and services in addition to the insurance coverage. Prudential also may arrange for third party vendors to provide goods and services at a discount (including without limitation beneficiary financial counseling services, employee assistance programs and travel assistance related services) to Covered Persons or their Beneficiaries. Though Prudential may make the arrangements, the third party vendors are solely liable for providing the goods and services. Prudential shall not be responsible for providing or failing to provide the goods and services to Covered Persons or their Beneficiaries. Further, Prudential shall not be liable to Covered Persons or their Beneficiaries for the negligent provision of the goods and services by third party vendors.

K. CONFORMITY WITH LAW.

If the provisions of the Group Contract do not conform to the requirements of any state or federal law or regulation that applies to the Group Contract, the Group Contract is automatically changed to conform with Prudential's interpretation of the requirements of that law or regulation.

Schedule of Plans

Effective Date: January 1, 2009

Group Contract No.: G-44028-TN-1

This Schedule of Plans sets forth the Plan of Benefits that applies to each Covered Class under the Group Contract listed below as of the Effective Date. The Plan of Benefits for a Covered Class is determined by: (1) the Group Insurance Certificates that apply to the Covered Class; and (2) any modification to those Certificates, provided the modification is listed below or included in an amendment to the Group Contract. A copy of each Certificate and any modification to it are attached to the Group Contract and made a part of it.

Covered Class:

All Employees included in the Covered Classes of the Group Insurance Certificate(s) listed below.

(1) The Coverage(s) described in the Group Insurance Certificate prepared for the Group Contract shown above:

   (a) With the Program Date of January 1, 2007; and

   (b) Bearing the code "44028, STD, FT and PT Employees, Ed 08-2006, 19".

(2) The Coverage(s) described in the Group Insurance Certificate prepared for the Group Contract shown above:

   (a) With the Program Date of January 1, 2009; and

   (b) Bearing the code "44028, LTD, All Employees, Ed 08-2009, 31".

U#44028-11906, 44028-020510

Application to

The Prudential Insurance Company of America (Prudential)

For Group Contract No. G-44028-TN-1

Applicant: HCA MANAGEMENT SERVICES, LP ON BEHALF OF THE PLAN ADMINISTRATION COMMITTEE

Address: One Park Plaza
Nashville, Tennessee 37203

The Group Contract is approved and its terms are accepted.

This Application is made in duplicate. One is attached to the Group Contract. The other is to be returned to Prudential.

It is agreed that this Application replaces any prior Application for the Group Contract.

HCA MANAGEMENT SERVICES, LP ON BEHALF OF THE PLAN ADMINISTRATION COMMITTEE

(By: CMS GP, LLC, its general partner)

_____
(Full or Corporate Name of Applicant)

Dated at _____ By _____
(Signature and Title)

On _____, 20_____ Witness _____
(To be signed by Resident Agent where required by law)

NOTICE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

U# 12122-0003, 44028-060512

AMENDMENT TO GROUP CONTRACT NO. G-44028-TN-1

By their signatures below, the Contract Holder and Prudential agree that the Group Contract is changed as follows:

- The insurance form listed below is attached to this Amendment; it forms part of the Group Contract as of its Effective Date.

  83500 MOD 1001 (44028-20), effective January 1, 2011

Date: , 20

- HCA MANAGEMENT SERVICES, LP ON BEHALF OF THE PLAN ADMINISTRATION COMMITTEE-
(Contract Holder)

By: CMS GP, LLC, its general partner

Witness:

By:
(Signature and Title)

Roseland, NJ

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

By: Natalie A Schmeidmiet
Vice President, Contracts

June 7, 2012

Modification of the Group Contract

The Group Contract is modified as follows:

This Modification changes the premium rate guarantee period for certain Coverage(s) from one month to one year. The Premium Rate Changes section of the General Rules limits Prudential's right to change premium rates. For as long as the Advance Premium Agreement remains in force in connection with the Group Contract, the following change is made to the Premium Rate Changes section with respect to the Coverages to which the Advance Premium Agreement applies:

Item (1) of Section C Premium Rate Changes is replaced with the following:

(1) As of any Contract Anniversary, provided 31 days written notice has been given to the Contract Holder; and

U# 44028-010213

AMENDMENT TO GROUP CONTRACT NO. G-44082-TN-1

By their signatures below, the Contract Holder and Prudential agree that the Group Contract is changed as follows:

- The insurance form listed in Column I below is attached to this Amendment; it forms part of the Group Contract as of its Effective Date. The form listed in Column I replaces, as of its Effective Date, the corresponding insurance form listed in Column II.

Column I	**Column II**
83500 SCH 1001 (S-1)(44028-20) effective January 1, 2013	83500 SCH 1001 (S-1)(44028-20) A effective April 1, 2012

Date: , 20

- HCA MANAGEMENT SERVICES, LP ON BEHALF OF THE PLAN ADMINISTRATION COMMITTEE -
(Contract Holder)

By: CMS GP, LLC, its general partner

Witness:

By:
(Signature and Title)

Roseland, NJ

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

By:
Vice President, Contracts

January 23, 2013

Schedule of Plans

Effective Date: January 1, 2013

Group Contract No.: G-44082-TN-1

This Schedule of Plans sets forth the Plan of Benefits that applies to each Covered Class under the Group Contract listed below as of the Effective Date. The Plan of Benefits for a Covered Class is determined by: (1) the Group Insurance Certificates that apply to the Covered Class; and (2) any modification to those Certificates, provided the modification is listed below or included in an amendment to the Group Contract. A copy of each Certificate and any modification to it are attached to the Group Contract and made a part of it.

Covered Class:

All Employees included in the Covered Classes of the Group Insurance Certificate(s) listed below.

Plan of Benefits that Applies to this Covered Class:

(1) The Coverage(s) described in the Group Insurance Certificate prepared for the Group Contract shown above:

(a) With the Program Date of January 1, 2013; and

(b) Bearing the code "44028, STD, FT and PT Employees, Ed 01-2013, 90".

The modifications to the Certificate described in the Notice to Employees:

(a) With an Effective Date of January 1, 2008; and

(b) Bearing the code "44028, PERM CNC, Ees Increasing STD, 01-01-2008, 58".

(2) The Coverage(s) described in the Group Insurance Certificate prepared for the Group Contract shown above:

(a) With the Program Date of January 1, 2013; and

(b) Bearing the code "44028, LTD, All Employees, Ed 01-2013, 91".

The modifications to the Certificate described in the Notice to Employees:

(a) With an Effective Date of July 1, 2009; and

(b) Bearing the code "44028, PERM CNC, Corp Admin Payroll Ees, 07-01-2009, 40".

(3) The Coverage(s) described in the Group Insurance Certificate prepared for the Group Contract shown above:

(a) With the Program Date of January 1, 2013; and

(b) Bearing the code "44028, STD, Core Plan, Ed 01-2013, 92".

(4) The Coverage(s) described in the Group Insurance Certificate prepared for the Group Contract shown above:

(a) With the Program Date of January 1, 2013; and

(b) Bearing the code "44028, STD, CorePlus Plan, Ed 01-2013, 93".

U# 12355-0003

AMENDMENT TO GROUP CONTRACT NO. G-44028-TN-1

By their signatures below, the Contract Holder and Prudential agree that the Group Contract is changed as follows:

- The insurance form listed in Column I below is attached to this Amendment; it forms part of the Group Contract as of its Effective Date. The form listed in Column I replaces, as of its Effective Date, the corresponding insurance form listed in Column II.

Column I	**Column II**
83500 MPP 1001 (44028-20) A effective January 1, 2013	83500 MPP 1001 (44028-20) effective April 1, 2012

Date: , 20

- HCA MANAGEMENT SERVICES, LP ON BEHALF OF THE PLAN ADMINISTRATION COMMITTEE -
(Contract Holder)

By: CMS GP, LLC, its general partner

Witness:

By:
(Signature and Title)

Roseland, NJ

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

By:
Vice President, Contracts

April 30, 2013

MODIFICATION OF GROUP CONTRACT'S BENEFITS AND PREMIUMS

"The Group Contract" means Group Contract No. G-44028-TN-1

This Modification is made because the Contract Holder has established an Employee Benefit Program apart from the Group Contract. The benefits under the Employee Benefit Program are similar to those under the Group Contract. This Modification applies only to the classes of Employees and the Coverages named in the Schedule, and only with respect to benefits that become due on and after the date this Modification takes effect. Benefits for Employees under the Coverages will become payable by Prudential under the Group Contract only after benefits payable by the Contract Holder under the Employee Benefit Program reach a limit as described in this Modification.

As used in this Modification, "Employees" means only Employees in the classes named in the Schedule and "Coverages" means only the Coverages of the Group Contract named in the Schedule.

When the term "Contract period" is used in this Modification, it means the following:

(1) First Contract period: April 1, 2012 – December 31, 2012

(2) Second Contract period: January 1, 2013 – December 31, 2013

(3) Third Contract period: January 1, 2014 – December 31, 2014

A Contract Period includes only the time during which the Group Contract is in effect.

A. SCHEDULE.

Class of Employees: All full-time or part-time Employees who are employed by HCA-Affiliated Facilities that have elected to offer the Core short term disability plan.

Coverages: Short Term Disability Coverage

Premium Rate:

	Monthly Rate Per Employee*
First Contract period	$4.38
Second Contract period	$5.60
Third Contract period	$5.60

*The Monthly Rate Per Employee may be adjusted while this Modification is in effect to reflect changes to the administrative fees paid to Sedgwick Claims Management Services, Inc.

	Factor Per Employee
Maximum Dollar Factor:	
First Contract period	$71.26 per month
Second Contract period	$94.68 per month
Third Contract period	$97.52 per month

	Factor Per Employee
Post-termination Dollar Factor:	
First Contract period	$255.43
Second Contract period	$263.09
Third Contract period	$270.98

Claim administration fee for claims submitted prior to the end of this Modification ("Run out Claims") – $269.00 per open claim.

B. WHILE THIS MODIFICATION IS IN EFFECT.

During the time this Modification is in effect:

(1) Prudential's obligation under the Group Contract as to Employees under the Coverages is governed by this Modification and by the Group Contract's Claim Rules.

(2) Until $855.13 in benefits become payable for the short term disability benefits of an Employee during the first Contract period, $1,136.19 in benefits become payable for the short term disability benefits of an Employee during the second Contract period or $1,170.28 in benefits become payable for the short term disability benefits of an Employee during the third Contract period, the benefit provisions of the Coverages with respect to that Employee are considered to be only a Benefit Formula. Benefit Formula amounts are used to compute the amount of benefits payable according to this Modification.

(2) In each Contract Period, Prudential is required to pay benefits under the Coverages only after the Benefit Maximum is reached. Once the Benefit Maximum is reached in a Contract Period, Prudential will pay the benefits that become due to Employees under the Coverages for the rest of that Contract Period.

The Benefit Maximum will be reached when the total amount of benefits that become due under the Benefit Formula during a Contract Period equals the amount of the Benefit Maximum. The amount of each benefit payable is determined under the Benefit Formula.

At any time during a Contract Period, the amount of the Benefit Maximum is equal to the product of (1), (2), and (3), where:

(1) is the Maximum Dollar Factor then in effect;

(2) is the greater of 12 and the total number of months in that Contract Period; and

(3) is the Average Number of Covered Employees.

While the Group Contract has been in effect for less than three months, the average Number of Covered Employees for this purpose is equal to the Number of Covered Employees on the first day of the Contract Period.

While the Group Contract has been in effect for three months or more, the average Number of Covered Employees for this purpose is computed as follows:

(a) The sum of the Numbers of Covered Employees on the first days of certain contract months is determined. The contract months used for this sum are (i) the last three contract months that began in the preceding Contract Period, if any, and (ii) all of the contract months that have begun in the current Contract Period and while this Modification is in effect, except for the last three.

(b) The sum in (a) is divided by the number of contract months used to determine that sum.

C. HOW THIS MODIFICATION MAY BE ENDED.

Prudential may end this Modification if the Contract Holder:

(1) Changes the Employee Benefit Program; or

(2) Does not supply enough funds to pay its obligations under the Employee Benefit Program for three working days in a row.

Unless the Contract Holder and Prudential have agreed otherwise, this Modification will end if any part of the Employee Benefit Program ends or if any part of the Group Contract ends.

In any event, the Contract Holder or Prudential may end this Modification on the day before any Premium Due Date of the Group Contract, but only if written notice of the termination is given to the other party at least 60 days before the Modification is to end.

D. AFTER THIS MODIFICATION ENDS.

As of the date this Modification ends, the part of the Group Contract which provides the Coverages for Employees will also end.

Once this Modification ends, the obligations of the Contract Holder and Prudential with respect to claims for benefits under the Coverages will be the same as they would be if the Modification had not ended, except as stated in this section.

If a benefit becomes due under the Coverages after this Modification ends, Prudential will pay the benefit, but only if that benefit:

(1) Results from a loss which occurred before this Modification ended or is payable only under an extension of benefits provision; and

(2) Becomes due after the earlier of (a) the date the Post-termination Maximum is reached, and (b) one year after the Modification ends.

The Post-termination Maximum will be reached when the total amount payable under the Coverages for benefits that become due after this Modification ends equals the amount of the Post-termination Maximum. In order for the benefits payable to count towards the Post-termination Maximum, the benefit:

(1) Must result from a loss which occurred before this Modification ended; or

(2) Must be payable only under an extension of benefits provision.

The amount of the Post-termination Maximum is equal to (1) times (2) where:

(1) is the Post-termination Dollar Factor then in effect; and

(2) is the average Number of Covered Employees. For this purpose, the average Number of Covered Employees is computed as follows:

(a) The sum of the Numbers of Covered Employees on the first days of certain contract months is determined. The contract months used for this sum are (i) the contract month in which the Modification ends, and (ii) the preceding two contract months, if any.

(b) The sum in (a) is divided by the number of contract months used to determine that sum.

E. PREMIUMS.

There is a premium charge payable each contract month that this Modification is in effect. An extra premium charge may be made at the end of each Contract Period and when this Modification ends. A separate extra premium charge will be made after this Modification ends.

For each contract month, the premium charge for the Coverages is equal to the product of (i) the number of Employees who are Covered Persons under at least one of the Coverages on the first day of the contract month, and (ii) the Premium Rate then in effect.

An extra premium is payable at the end of each Contract Period if this Modification is still in effect at that time, and when this Modification ends, unless Prudential provides written notice that it has waived all or a portion of the extra premium. This is in addition to all other premiums payable under the Group Contract. It is equal to the excess, if any, of (1) over (2) below. As used in (1) and (2), "Current Contract Period" means either the Contract Period just ending or the Contract Period which this Modification ends. "Preceding Contract Period means the Contract Period preceding the Current Contract Period.

(1) The Premium Maximum as of the end of the current Contract Period, or as of the date this Modification ends. The amount of the Premium Maximum is equal to the product of (a), (b), and (c) where:

(a) is the Maximum Dollar Factor in effect;

(b) is the number of months that this Modification was in effect during the current Contract Period; and

(c) is the average Number of Covered Employees.

While the Group Contract has been in effect for less than three months, the Average number of Covered Employees for this purpose is equal to the Number of Covered Employees on the first day of the current Contract Period.

While the Group Contract has been in effect for three months or more, the average Number of Covered Employees for this purpose is computed as follows:

(i) The sum of the Numbers of Covered Employees on the first days of certain contract months is determined, the contract months used for this sum are (A) the last three contract months that began in the preceding Contract Period, if any, and (B) all of the contract months that have begun in the current Contract Period and while this Modification is in effect, except for the last three.

(ii) The sum in (i) is divided by the number of contract months used to determine that sum.

(2) The total amount of benefits payable under the Benefit Formula for claims that are due during the current Contract Period. The total Benefit Formula amount does not include any benefits that become due after this Modification ends.

After this Modification ends, a separate extra premium is payable. This is in addition to all other premiums payable under the Group Contract or under this section of the Modification. It is equal to the excess, if any, of (1) over (2) below:

(1) The Post-termination Maximum (see Section D).

(2) The total amount payable under the Benefit Formula for benefits that become due after this Modification ends. This amount includes only benefits which become due within one year after this Modification ends, and:

(a) Result from losses which occurred before this Modification ended; or

(b) Are payable only under an extension of benefits provision.

Prudential will compute the amount of this extra premium after one year has elapsed since the Modification ended. The Contract Holder will pay Prudential this amount within 30 days of the date Prudential tells the Contract Holder what amount is due.

F. GENERAL PROVISIONS.

When two or more classes of Employees are shown in the Schedule, amounts under this Modification are computed separately for each class and then considered as a whole.

The Premium Rate, Maximum Dollar Factor and Post-termination Dollar Factor shown in the Schedule are those in effect under this Modification as of the date this Modification takes effect. Prudential may change this rate and these factors when the Contract Holder changes the Employee Benefit Program. Prudential may also change this rate and these factors at the same times and under the same conditions as those stated for premium rates for the Coverages in the Premium Rates Changes section of the Group Contract's General Rules.

Benefits become due when the Contract Holder or Prudential receives proof of a valid claim for those benefits, as described in the Group Contract's Claim Rules. The Contract Holder and Prudential may agree on a different way to determine when benefits become due under this Modification, but it must produce about the same result.

Prudential decides the amount of benefits for which a person qualifies under the Benefit Formula. Benefits payable under the Employee Benefit Program are based on that decision. If Prudential decides that no benefit is payable for a claim or for part of a claim, and if this decision results in a law suit, Prudential will defend that suit at its own expense. Prudential has the right to settle the suit. The Contract Holder will pay any benefit amount included in a judgment or settlement unless Prudential is required to pay it by the other terms of this Modification.

If benefits become due under the Employee Benefit Program, and those benefits are not paid by the Contract Holder, Prudential will arrange to pay those benefits for the Contract Holder. But Prudential will not arrange to pay any benefits for the Contract Holder that become due more than one year after this Modification ends. If for any reason Prudential pays an amount of benefits which, by the terms of this Modification, should have been paid under the Employee Benefit Program, the Contract Holder will reimburse Prudential for that amount. If for any reason the Contract Holder pays an amount of benefits which, by the terms of this Modification, Prudential should have paid, Prudential will reimburse the Contract Holder for that amount.

Prudential is not liable for benefits, except as stated in the Group Contract as modified by this Modification. The Contract Holder is not liable for benefits if they are payable by Prudential under the Group Contract as modified by this Modification. The obligations of the Contract Holder under the Employee Benefit Program and Prudential under the Group Contract as modified by this Modification are mutually exclusive.

The Contract Holder will give Prudential the facts it needs to apply the terms of this Modification. The Contract Holder will tell Prudential at once if the Employee Benefit Program is changed or ends.

HCA Management Services

Long Term Disability Coverage

Prudential

PRU 77212-000458-000026

Disclosure Notice

FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Disability Management Services Claim Division
P.O. Box 13480
Philadelphia, Pennsylvania 19176
1-800-842-1718

If Prudential fails to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494

FOR ARIZONA RESIDENTS

Notice: This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

FOR FLORIDA RESIDENTS

The benefits of the policy providing your coverage are governed by the law of a state other than Florida.

FOR INDIANA RESIDENTS

Questions regarding your policy or coverage should be directed to:

The Prudential Insurance Company of America
(800) 842-1718

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

FOR MARYLAND RESIDENTS

The Group Insurance Contract providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

FOR OKLAHOMA RESIDENTS

Notice: Certificates issued for delivery in Oklahoma are governed by the certificate and Oklahoma laws not the state where the master policy was issued.

FOR WISCONSIN RESIDENTS

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

Problems with Your Insurance? – If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Disability Management Services Claim Division
P.O. Box 13480
Philadelphia, PA 19176
1-800-842-1718

You can also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the Office of the Commissioner of Insurance by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

THIS NOTICE IS FOR TEXAS RESIDENTS ONLY

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771

Web: http://www.tdi.state.tx.us

Email: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact Prudential first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771

Web: http://www.tdi.state.tx.us

Email: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Prudential primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es sólo para propósito de información y no se convierte en parte o condición del documento adjunto.

Benefit Highlights

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you have a long period of disability. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled. Benefits start after the elimination period.

Program Date: January 1, 2013

Contract Holder: HCA MANAGEMENT SERVICES, LP ON BEHALF OF THE PLAN ADMINISTRATION COMMITTEE

Group Contract Number: G-44028-TN-1

Covered Classes: Class 1: All Corporate full-time hourly and salaried Employees in active employment in the United States with the Employer.

Class 2: All Non-Corporate full-time hourly and salaried Employees in active employment in the United States with the Employer.

Class 3: All full-time Employees, as designated by the former Health Midwest Division, in active employment in the United States with the Employer.

Class 4: All full-time Non-Management Employees who are approved participants in the Summer Time-Off Program in active employment in the United States with the Employer.

Part-time, temporary and seasonal workers are excluded from coverage.

Minimum Hours Requirement: Employees must be working at least 32 hours per week.

Employment Waiting Period: You may need to work for your Employer for a continuous period before you become eligible for the plan. The period must be agreed upon by your Employer and Prudential.

Your Employer will let you know about this waiting period.

Elimination Period: 147 days.

Benefits begin the day after the Elimination Period is completed.

Monthly Benefit: Your monthly benefit depends on the Option for which you are enrolled.

Option 1: No Coverage.

Option 2: 50% of your monthly earnings, but not more than the Maximum Monthly Benefit.

Option 3: 60% of your monthly earnings, but not more than the Maximum Monthly Benefit.

Your benefit may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may be limited under this coverage.

Maximum Monthly Benefit: $10,000.00.

Maximum Period of Benefits:

Your Age on Date Disability Begins	Your Maximum Benefit Duration
Under age 62	To your normal retirement age*
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months

***Your normal retirement age is your retirement age under the Social Security Act where retirement age depends on your year of birth.**

No contributions are required for your coverage while you are receiving payments under this plan.

Cost of Coverage: The long term disability plan is provided to you on a contributory basis. You will be informed of the amount of your contribution when you enroll.

The above items are only highlights of your coverage. For a full description please read this entire Group Insurance Certificate.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 44028.**

If you are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

Table of Contents

The Prudential Insurance Company of America

Certificate of Coverage

The Prudential Insurance Company of America (referred to as Prudential) welcomes you to the plan.

This is your Certificate of Coverage as long as you are eligible for coverage and you meet the requirements for becoming insured. You will want to read this certificate and keep it in a safe place.

Prudential has written this certificate in booklet format to be understandable to you. If you should have any questions about the content or provisions, please consult Prudential's claims paying office. Prudential will assist you in any way to help you understand your benefits.

The benefits described in this Certificate of Coverage are subject in every way to the entire Group Contract which includes this Group Insurance Certificate.

Prudential's Address

The Prudential Insurance Company of America
751 Broad Street
Newark, New Jersey 07102

Customer Service Office

The Prudential Insurance Company of America
Disability Management Services Claim Division
P.O. Box 13480
Philadelphia, Pennsylvania 19176
1-800-842-1718

General Provisions

What Is the Certificate?

This certificate is a written document prepared by Prudential which tells you:

- the coverage to which you may be entitled;
- to whom Prudential will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

General Definitions used throughout this certificate include:

You means a person who is eligible for Prudential coverage.

We, us, *and* ***our*** means The Prudential Insurance Company of America.

Employee means a person who is in ***active employment*** with the ***Employer*** for the minimum hours requirement.

Active employment means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least 32 hours per week. If you are a partner or proprietor of the Employer, that work must be in the conduct of the Employer's business.

Your worksite must be:

- your Employer's usual place of business;
- an alternate work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation and jury duty are considered active employment.

Temporary and seasonal workers are excluded from coverage.

Individuals whose employment status is being continued under a severance or termination agreement will not be considered in active employment.

Employer means Employers who are HCA Inc.'s subsidiaries or affiliates.

Contract Holder means HCA MANAGEMENT SERVICES, LP ON BEHALF OF THE PLAN ADMINISTRATION COMMITTEE to whom the Group Contract is issued.

Insured means any person covered under a coverage.

Plan means a line of coverage under the Group Contract.

When Are You Eligible for Coverage?

If you are working for your Employer in a ***covered class***, the date you are eligible for coverage is the later of:

- the plan's program date; and
- the day after you complete your ***benefit waiting period***.

You do not have to complete a new benefit waiting period if:

- your insurance ends because you stop working for your Employer for any reason; and
- you resume working for your Employer in a covered class within 180 days after your insurance ended.

Covered class means your class as determined by the Contract Holder. This will be done under the Contract Holder's rules, on dates the Contract Holder sets. The Contract Holder must not discriminate among persons in like situations. You cannot belong to more than one class for insurance on each basis, Contributory or Non-contributory Insurance, under a plan. "Class" means covered class, benefit class or anything related to work, such as position or earnings, which affects the insurance available. If you are an employee of more than one Employer included under the Group Contract, for the insurance you will be considered an employee of only one of those Employers. Your service with the others will be treated as service with that one.

Benefit waiting period means the continuous period of time that you must be employed by your Employer before you are eligible for coverage under a plan. The period must be agreed upon by the Employer and Prudential.

When Does Your Coverage Begin?

When you and your Employer share the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you enroll for it on or before that date;
- the date you enroll for coverage, if you enroll for it within 31 days after the date you are eligible for coverage;
- the date designated by the Employer, if you enroll during the ***annual enrollment period***;
- the date Prudential approves your application, if ***evidence of insurability*** is required; or
- the date you are in active employment. If you are not in active employment on the date your coverage would normally begin, it will begin on the date you return to active employment except as provided under the What If You Are Not in Active Employment When Your Employer Changes Insurance Carriers to Prudential section.

Annual enrollment period means a period each year when you may enroll for coverage or request a change for the following calendar year. Your Employer will notify you of when this Annual Enrollment Period begins and ends.

Evidence of insurability means a statement of your medical history which Prudential will use to determine if you are approved for coverage.

What If You Are Not in Active Employment When Your Employer Changes Insurance Carriers to Prudential?

Prudential will provide coverage for you if this long term disability plan replaces your Employer's prior plan and:

- you were covered by the prior plan on the day before this plan became effective; and
- you are not in active employment because of a sickness or injury.

Contributions are required for your coverage.

Your coverage will be limited to the amount that would have been paid by your Employer's prior plan. Prudential will reduce your monthly payment under this plan by any amount that is payable under your Employer's prior plan.

When Is Evidence of Insurability Required?

In any of these situations, you must give evidence of insurability, provided at your expense. This requirement will be met when Prudential decides the evidence is satisfactory.

- You enroll for coverage more than 31 days after the date you are first eligible for it.
- You enroll for an increase in coverage during an annual enrollment period.
- You re-enroll for coverage after you voluntarily cancelled it.
- You enroll after any coverage ends because you did not pay a required contribution.

Evidence of insurability is not required if:

- you are rehired within 180 days and you re-enroll for your prior level of coverage; or
- you enroll for coverage or an increase in coverage within 31 days of a ***change in status***. The definition of change in status is shown in the What Happens If You Experience a Change in Status? section below.

An evidence of insurability form can be obtained from your Employer.

How Do You Enroll For Coverage?

You must enroll on a form approved by Prudential and agree to pay the required contributions.

When May You Elect to Change Your Coverage?

You may elect to change your coverage during the annual enrollment period or within 31 days of a change in status. You must elect to change your coverage on a form approved by Prudential and agree to pay the required contributions.

When Will Changes to Your Coverage Take Effect?

Once your coverage begins, any increased or additional coverage will take effect on the latest of:

1. the effective date of the change, if you are:
   - in active employment;
   - on a temporary layoff;
   - on leave of absence; or
   - working ***reduced hours***, for reasons other than disability.
2. the date Prudential approves your application, if evidence of insurability is required; or
3. the date you return to active employment, if you are not in active employment due to injury or sickness.

An increase in your long term disability coverage may be subject to a pre-existing condition limitation as described in the plan. Any decrease in coverage will take effect immediately upon the effective date of the change. Neither an increase nor a decrease in coverage will affect a ***payable claim*** that occurs prior to the increase or decrease.

Reduced hours means you are working less than the number of hours required to be considered in active employment.

Payable claim means a claim for which Prudential is liable under the terms of the Group Contract.

What Happens If You Experience a Change in Status?

If you experience a ***change in status***, you may enroll for coverage or elect an increase in your coverage by enrolling in another plan option within 31 days of a change in status. Evidence of insurability will not be required. You must enroll for coverage or an increase in your coverage on a form approved by Prudential and agree to pay the required contributions.

Any enrollment or increased or additional coverage will become effective on the later of:

- the date you enroll for the increased or additional coverage; or
- if you are not in active employment due to injury or sickness, the date you return to active employment.

Change in status means a change in status as defined in the regulations under Internal Revenue Code section 125, unless your Employer's cafeteria plan document or human resource policy contains more restrictive provisions. In that event, your Employer may restrict the situations where you can change your coverage.

Once Your Coverage Begins, What Happens If You Are Temporarily Not Working Or If You Are Working Reduced Hours?

If you are on severance under the terms of a collective bargaining agreement, and if premium is paid, you will be covered while you are eligible under the severance package, until the earlier of: (1) up to 12 weeks from the date your severance begins, in accordance with the collective bargaining agreement; or (2) the date you become covered under another employer's long term disability coverage.

If you are on a ***temporary layoff***, and if premium is paid, you will be covered to the end of the month in which your temporary layoff begins.

If you are on a ***leave of absence***, and if premium is paid, you will be covered for up to 6 months from the date your leave of absence begins. But, with respect to leave of absence under the federal Family and Medical Leave Act of 1993 (FMLA) or similar state law, if it is the Contract Holder's policy to allow a longer period of continued coverage for FMLA leaves, this policy will be used to determine the period of continued coverage for your FMLA leave. Continuation of such coverage pursuant to this provision is contingent upon Prudential's timely receipt of premium payments and written confirmation of your FMLA leave by the Contract Holder.

If you are working reduced hours, for reasons other than disability, and if premium is paid, you will be covered to the end of the month following the month in which your reduced hours begin.

Temporary layoff means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by the Contract Holder, other than for reasons in connection with any severance or termination agreement. Your normal vacation time, any period of disability or FMLA leave is not considered a temporary layoff.

Leave of absence means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by the Contract Holder, other than for reasons in connection with any severance or termination agreement. Your normal vacation time or any period of disability is not considered a leave of absence.

When Does Your Coverage End?

Your coverage under the Group Contract or a plan ends on the earliest of:

- the date the Group Contract or a plan is canceled;
- the date you are no longer a member of the covered classes;
- the date your covered class is no longer covered;
- the last day of the period for which you made any required contributions;
- the last day you are in active employment except as provided under the Once Your Coverage Begins, What Happens If You Are Temporarily Not Working Or If You Are Working Reduced Hours? section; or
- the date you are no longer in active employment due to a disability that is not covered under the plan. The disabilities that are not covered are shown in the What Disabilities Are Not Covered Under Your Plan? section of the Long Term Disability Coverage Benefit Information pages.

Does the Coverage under a Plan Replace or Affect any Workers' Compensation or State Disability Insurance?

The coverage under a plan does not replace or affect the requirements for coverage by workers' compensation or state disability insurance.

Does Your Employer Act as Prudential's Agent?

For purposes of the Group Contract, your Employer acts on its own behalf. Under no circumstances will your Employer be deemed the agent of Prudential.

Does This Certificate Address Any Rights to Other Benefits or Affect Your Employment with Your Employer?

This certificate sets forth only the terms and conditions for coverage and receipt of benefits for Long Term Disability. It does not address and does not confer any rights, or take away any rights, if any, to other benefits or employment with your Employer. Your rights, if any, to other benefits or employment are solely determined by your Employer. Prudential plays no role in determining, interpreting, or applying any such rights that may or may not exist.

How Can Statements Made in Your Application for this Coverage be Used?

Prudential considers any statements you or your Employer make in a signed application for coverage a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

If a statement is used in a contest, a copy of that statement will be furnished to you or, in the event of your death or incapacity, to your eligible survivor or personal representative.

A statement will not be contested after the amount of insurance has been in force, before the contest, for at least two years during your lifetime.

We will use only statements made in a signed application as a basis for doing this.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

Long Term Disability Coverage

BENEFIT INFORMATION

How Does Prudential Define Disability?

You are disabled when Prudential determines that:

- you are unable to perform the ***material and substantial duties*** of your ***regular occupation*** due to your ***sickness*** or ***injury***; and
- you are under the ***regular care*** of a ***doctor***; and
- you have a 20% or more loss in your ***monthly earnings*** due to that sickness or injury.

After 24 months of payments, you are disabled when Prudential determines that due to the same sickness or injury:

- you are unable to perform the duties of any ***gainful occupation*** for which you are reasonably fitted by education, training or experience; and
- you are under the regular care of a doctor.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Prudential will assess your ability to work and the extent to which you are able to work by considering the facts and opinions from:

- your doctors; and
- doctors, other medical practitioners or vocational experts of our choice.

When we may require you to be examined by doctors, other medical practitioners or vocational experts of our choice, Prudential will pay for these examinations. We can require examinations as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Prudential Representative. Refusal to be examined or interviewed may result in denial or termination of your claim.

Material and substantial duties means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

Regular occupation means the occupation you are routinely performing when your disability begins. Prudential will look at your occupation as it is normally performed in the national economy instead of how the work tasks are performed for a specific employer or at a specific location. An occupation that provides you with less than 60% of your monthly earnings is not considered your regular occupation.

Sickness means any disorder of your body or mind, but not an injury. Sickness includes pregnancy, abortion, miscarriage, childbirth, and any complication related to pregnancy. Disability must begin while you are covered under the plan.

Injury means a bodily injury that:

- is the direct result of an accident;
- is not related to any cause other than the accident; and
- results in immediate disability.

Disability must begin while you are covered under the plan.

Regular care means:

- you personally visit a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for your disabling condition(s) by a doctor whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

Doctor means a person who is performing tasks that are within the limits of his or her medical license; and

- is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Prudential will not recognize any relative including, but not limited to, you, your spouse, or a child, brother, sister, or parent of you or your spouse as a doctor for a claim that you send to us.

For All Corporate full-time Hourly and Salaried Employees:

Monthly earnings means your base rate of pay plus commissions* in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, a voluntary non-qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from bonuses, shift differential, overtime pay, any other extra compensation, or income received from sources other than your Employer.

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

For Commission Salespersons:

Monthly earnings means your base rate of pay plus commissions* in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, a voluntary non-qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from commissions but does not include renewal commissions, bonuses, shift differential, overtime pay or any other extra compensation, or income received from sources other than your Employer.

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

For Pieceworkers ONLY:

Monthly earnings means your pay is calculated on your average monthly pieceworker earnings for the three (3) months prior to the period your disability begins.

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect for the three (3) months just prior to the date your absence begins.

For All Other Non-Corporate Employees:

Monthly earnings means your base rate of pay plus commissions* in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, a voluntary non-qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from bonuses, shift differential, overtime pay, any other extra compensation, or income received from sources other than your Employer.

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

For Class 4 Employees:

Monthly earnings means $1/12^{th}$ of your gross annualized income from your Employer in effect just prior to your date of disability. Annualized income is based on your current rate of pay multiplied by your regularly scheduled hours multiplied by 26 pay periods. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer.

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

*Commission will be averaged for the lesser of:

(a) the 12 full calendar month period of your employment with your Employer just prior to the date your disability begins; or

(b) the period of actual employment with your Employer.

Gainful occupation, if you enrolled for Option 2 or Option 3, means an occupation, including self employment, that is or can be expected to provide you with an income within 12 months of your return to work, that exceeds:

- 80% of your ***indexed monthly earnings***, if you are working; or
- 60% of your monthly earnings, if you are not working.

Indexed monthly earnings means your monthly earnings as adjusted on each July 1 provided you were disabled for all of the 12 months before that date. Your monthly earnings will be adjusted on that date by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-W) is published by the U.S. Department of Labor. Prudential reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W.

Indexing is only used to determine your percentage of lost earnings while you are disabled and working.

How Long Must You Be Disabled Before Your Benefits Begin?

You must be continuously disabled through your ***elimination period***. Prudential will treat your disability as continuous if your disability stops for 30 consecutive days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

Your elimination period is 147 days.

Elimination period means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Prudential. If you become covered under a group long term disability plan that replaces this plan during your elimination period, your elimination period under this plan will not be met.

Can You Satisfy Your Elimination Period If You Are Working?

Yes, provided you meet the definition of disability.

When Will You Begin to Receive Disability Payments?

You will begin to receive payments when we approve your claim, providing the elimination period has been met. We will send you a payment each month for any period for which Prudential is liable.

How Much Will Prudential Pay If You Are Disabled and Not Working?

We will follow this process to figure out your ***monthly payment***:

1. If you are enrolled for Option 2, multiply your monthly earnings by 50%. But, if you are enrolled for Option 3, multiply your monthly earnings by 60%.

2. The ***maximum monthly benefit*** is $10,000.00.

3. Compare the answer in item 1 with the maximum monthly benefit. The lesser of these two amounts is your ***gross disability payment***.

4. Subtract from your gross disability payment any ***deductible sources of income***.

That amount figured in item 4 is your monthly payment.

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30th of your payment for each day of disability.

Monthly payment means your payment after any deductible sources of income have been subtracted from your gross disability payment.

Maximum monthly benefit means the maximum benefit amount for which you are insured under this plan.

Gross disability payment means the benefit amount before Prudential subtracts deductible sources of income and disability earnings.

Deductible sources of income means income from deductible sources listed in the plan that you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

How Much Will Prudential Pay If You Work While You Are Disabled?

We will send you the monthly payment if you are disabled and your monthly ***disability earnings***, if any, are less than 20% of your indexed monthly earnings due to the same sickness or injury.

If you are disabled and your monthly disability earnings are 20% or more of your indexed monthly earnings, due to the same sickness or injury, Prudential will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.

2. Compare the answer in item 1 to your indexed monthly earnings.

If the answer from item 1 is less than or equal to 100% of your indexed monthly earnings, Prudential will not further reduce your monthly payment.

If the answer from item 1 is more than 100% of your indexed monthly earnings, Prudential will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.

2. Divide the answer in item 1 by your indexed monthly earnings. This is your percentage of lost earnings.

3. Multiply your monthly payment by the answer in item 2.

This is the amount Prudential will pay you each month.

If your monthly disability earnings exceed 80% of your indexed monthly earnings, Prudential will stop sending you payments and your claim will end.

Prudential may require you to send proof of your monthly disability earnings on a monthly basis. We will adjust your payment based on your monthly disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, including copies of your IRS federal income tax return, W-2's and 1099's, which we believe are necessary to substantiate your income.

Disability earnings means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your greatest extent possible. This would be, based on your restrictions and limitations:

- During the first 24 months of disability payments, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.
- Beyond 24 months of disability payments, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

Salary continuance paid to supplement your disability earnings will not be considered payment for work performed.

What Happens If Your Disability Earnings Fluctuate?

If your disability earnings are expected to fluctuate widely from month to month, Prudential may average your disability earnings over the most recent 3 months to determine if your claim should continue subject to all other terms and conditions in the plan.

If Prudential averages your disability earnings, we will terminate your claim if the average of your disability earnings from the last 3 months exceeds 80% of indexed monthly earnings.

We will not pay you for any month during which disability earnings exceed the above amounts.

What Are Deductible Sources of Income?

Prudential will deduct from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive as loss of time benefits under:

   (a) a workers' compensation law;

   (b) an occupational disease law; or

   (c) any other ***act*** or ***law*** with similar intent.

2. The amount that you receive or are entitled to receive as loss of time disability income payments under any:

   (a) state compulsory benefit ***act*** or ***law***.

   (b) automobile liability insurance policy required by ***law***.

   (c) other group insurance plan.

   (d) governmental retirement system as the result of your job with your Employer.

   Amounts you receive or are entitled to receive under any blanket group or franchise school accident policy will not be included.

3. The gross amount that you, your spouse and children receive or are entitled to receive as loss of time disability payments because of your disability under:

   (a) the United States Social Security Act;

   (b) the Canada Pension Plan;

   (c) the Quebec Pension Plan; or

   (d) any similar ***plan*** or ***act***.

   Amounts paid to your former spouse or to your children living with such spouse will not be included.

4. The gross amount that you receive as retirement payments or the gross amount your spouse and children receive as retirement payments because you are receiving payments under:

   (a) the United States Social Security Act;

   (b) the Canada Pension Plan;

   (c) the Quebec Pension Plan; or

   (d) any similar ***plan*** or ***act***.

   Benefits paid to your former spouse or to your children living with such spouse will not be included.

5. The amount that you:

   (a) receive as disability payments under your Employer's ***retirement plan***;

   (b) voluntarily elect to receive as retirement or early retirement payments under your Employer's retirement plan; or

   (c) receive as retirement payments when you reach normal retirement age, as defined in your Employer's retirement plan.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefits which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are paid based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefits under the plan will also be considered as a retirement benefit.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Prudential will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

6. The amount you receive under Title 46, United States Code Section 688 (The Jones Act). This includes only the "wages" part of such benefits.

7. The amount that you receive, due to your disability, from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

8. The amount of loss of time benefits that you receive or are entitled to receive under any ***salary continuation or accumulated sick leave*** to the extent that your monthly payment and deductible sources of income, including any other group and/or individual disability benefits, exceed or would exceed 100% of your monthly earnings.

With the exception of retirement payments, Prudential will only subtract deductible sources of income which are payable as a result of the same disability.

We will not reduce your payment by your Social Security retirement payments if your disability begins after age 65 and you were already receiving Social Security retirement payments.

Law, plan or act means the original enactment of the law, plan or act and all amendments.

Retirement plan means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions.

Salary continuation or accumulated sick leave means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Group Contract. This continued payment must be part of an established plan maintained by your Employer for the benefit of an employee covered under the Group Contract. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account as such, in calculating your monthly payment.

What Are Not Deductible Sources of Income?

Prudential will not deduct from your gross disability payment income you receive from, but not limited to, the following sources:

- 401(k) plans;
- profit sharing plans;
- thrift plans;
- tax sheltered annuities;
- stock ownership plans;
- non-qualified plans of deferred compensation;
- pension plans for partners;
- military pension and disability income plans;
- credit disability insurance;
- franchise disability income plans;
- a retirement plan from another Employer;
- individual retirement accounts (IRA).
- individual disability income plans.

What If Subtracting Deductible Sources of Income Results in a Zero Benefit? (Minimum Benefit)

The minimum monthly payment is $50.00.

Prudential may apply this amount toward an outstanding overpayment.

What Happens When You Receive a Cost of Living Increase from Deductible Sources of Income?

Once Prudential has subtracted any deductible source of income from your gross disability payment, Prudential will not further reduce your payment due to a cost of living increase from that source.

What If Prudential Determines that You May Qualify for Deductible Income Benefits?

If we determine that there is a reasonable expectation that you may qualify for benefits under item 1, 2, or 3 in the deductible sources of income section, and there is a reasonable expectation that the benefits can be estimated we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amount if such benefits have not been awarded.

However, we will NOT reduce your payment by the estimated amount under item 1, 2, or 3 in the deductible sources of income section if you:

- apply for the benefits;
- appeal any denial to all administrative levels Prudential feels are necessary; and
- sign Prudential's Reimbursement Agreement form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Prudential feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If we determine that there is a reasonable expectation that you may qualify for benefits under item 8 in the deductible sources of income section, and there is a reasonable expectation that the benefit amounts can be estimated we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amount if such benefits have not been received.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount received; or
- that benefits have been denied. In this case, a lump sum refund of the estimated amount will be made to you.

What Happens If You Receive a Lump Sum Payment?

If you receive a lump sum payment from any deductible source of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one.

How Long Will Prudential Continue to Send You Payments?

Prudential will send you a payment each month up to the ***maximum period of payment***. Your maximum period of payment is:

Your Age on Date Disability Begins	Your Maximum Period of Benefits
Under age 62	To your normal retirement age*
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months

***Your normal retirement age is your retirement age under the Social Security Act where retirement age depends on your year of birth.**

We will stop sending you payments while you are incarcerated as a result of a conviction.

We will stop sending you payments and your claim will end on the earliest of the following:

1. During the first 24 months of payments, when you are able to work in your regular occupation on a ***part-time basis*** but you choose not to; after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to.
2. The end of the maximum period of payment.
3. The date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under the Rehabilitation Services section.
4. The date you fail to submit proof of continuing disability satisfactory to Prudential.
5. After 12 months of payments if you are considered to reside outside of the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.
6. The date your disability earnings exceed the amount allowable under the plan.
7. The date you die.
8. The date you decline to participate in a rehabilitation program that Prudential considers appropriate for your situation and that is approved by an independent doctor.

Maximum period of payment means the longest period of time Prudential will make payments to you for any one period of disability.

Part-time basis means the ability to work and earn 20% or more of your indexed monthly earnings.

What Disabilities Have a Limited Pay Period Under Your Plan?

Disabilities which, as determined by Prudential, are due in whole or part to ***mental illness*** or ***substance related disorders*** have a limited pay period.

The limited pay period for mental illness or substance related disorders is 24 months.

Prudential will continue to send you payments for disabilities due in whole or part to mental illness or substance related disorders beyond the 24 month period if you meet one or both of these conditions:

1. If you are ***confined*** to a ***hospital or institution*** at the end of the 24 month period, Prudential will continue to send you payments during your ***confinement***.

   If you are still disabled when you are discharged, Prudential will send you payments for a recovery period of up to 90 days.

   If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Prudential will send payments during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to item 1, if, after the 24 month period for which you have received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 days in a row, Prudential will send payments during the length of the confinement.

Prudential will not pay beyond the limited pay period as indicated above, or the maximum period of payment, whichever occurs first.

Prudential will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine.

Mental illness means a psychiatric or psychological condition regardless of cause. Mental illness includes but is not limited to schizophrenia, depression, manic depressive or bipolar illness, anxiety, somatization, and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine. But, mental illness does not include substance related disorders.

Substance related disorders means alcoholism or the non-medical use of narcotics, sedatives, stimulants, hallucinogens or any other such substance.

Confined or confinement for this section means a hospital stay of at least 8 hours per day.

Hospital or institution means an accredited facility licensed to provide care and treatment for the condition causing your disability.

What Disabilities Are Not Covered Under Your Plan?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries;
- active participation in a riot; or
- commission of a crime for which you have been convicted under state or federal law.

Your plan does not cover a disability due to a pre-existing condition.

Your plan does not cover a disability due to war, declared or undeclared, or any act of war.

What Is a Pre-Existing Condition?

You have a pre-existing condition if both 1. and 2. are true:

1. (a) You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the 3 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available; or

   (b) you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available.

2. Your disability begins within 12 months of the date your coverage under the plan becomes effective.

How Does a Pre-Existing Condition Affect an Increase in Your Benefits?

If there is an increase in your benefits due to an amendment of the plan or your enrollment in another plan option, a benefit limit will apply if your disability is due to a pre-existing condition.

You will be limited to the benefits you had on the day before the increase. The increase will not take effect until your disability ends.

How Do the Pre-Existing Condition Provisions Work If Your Employment Ends and You Are Rehired?

Your prior period of coverage under this plan will be applied for the purposes of satisfying the pre-existing condition requirements if:

- your insurance ends because you stop working for your Employer for any reason;
- you resume working for your Employer; and
- you become covered under this plan within 180 days after your insurance ended.

How Do the Pre-Existing Condition Provisions Work If You Were Covered Under Your Employer's Prior Plan?

Special rules apply to pre-existing conditions, if this long term disability plan replaces your Employer's prior plan and:

- you were covered by that plan on the day before this plan became effective; and
- you became covered under this plan within thirty-one days of its effective date.

The special rules are:

1. If the Employer's prior plan did not have a pre-existing condition exclusion or limitation, then a pre-existing condition will not be excluded or limited under this plan.
2. If the Employer's prior plan did have a pre-existing condition exclusion or limitation, then the limited time does not end after the first 12 months of coverage. Instead it will end on the date any equivalent limit would have ended under the Employer's prior plan.
3. If the change from your Employer's prior plan to this plan of coverage would result in an increase in your amount of benefits, the benefits for your disability that is due to a pre-existing sickness or injury will not increase. Instead the benefits are limited to the amount you had on the day before the plan change. This applies whether or not the Employer's prior plan had a pre-existing condition exclusion or limitation.

What Happens If You Return to Work Full Time and Your Disability Occurs Again?

If you have a ***recurrent disability***, as determined by Prudential, we will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under this plan for the period between your prior claim and your current disability; and
- your recurrent disability occurs within 3 months of the end of your prior claim.

Your recurrent disability will be subject to the same terms of the plan as your prior claim. Any disability which occurs after 3 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the plan provisions.

If you become covered under any other group long term disability plan, you will not be eligible for payments under the Prudential plan.

Recurrent disability means a disability which is:

- caused by a worsening in your condition; and
- due to the same cause(s) as your prior disability for which Prudential made a Long Term Disability payment.

Long Term Disability Coverage

OTHER BENEFIT FEATURES

What Benefits Will be Provided to Your Family If You Die? (Survivor Benefit)

When Prudential receives proof that you have died, we will pay your ***eligible survivor*** a survivor benefit equal to 3 months of your gross disability payment.

The survivor benefit will be paid if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If a benefit is payable to a person who is a minor or not capable of giving a valid release for any payment due, Prudential may, at its option, pay the amount payable to that person or to any person or institution that appears to Prudential to have assumed the custody and main support of that person. If any amount is so paid, Prudential will not have to pay that amount again.

If you have no eligible survivors, payment will be made to your estate.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

Eligible survivor means your spouse, if living; otherwise, your children under age 25.

Long Term Disability Coverage

OTHER SERVICES

How Can Prudential Help Your Employer Identify and Provide Worksite Modification?

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Prudential.

When this occurs, Prudential will reimburse your Employer for the cost of the modification up to the greater of:

- $1000; or
- the equivalent of two months of your gross disability payment.

This benefit is available to you on a one time only basis.

How Can Prudential's Social Security Claimant Assistance Program Help You With Obtaining Social Security Disability Benefits?

Prudential can arrange for expert advice regarding your Social Security disability benefits claim and assist you with your application or appeal, if you are disabled under the plan.

Receiving Social Security disability benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:

- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.

Long Term Disability Coverage

REHABILITATION SERVICES

How Can Prudential's Rehabilitation Program Help You Return to Work?

Prudential has a ***rehabilitation program*** available.

As your file is reviewed, medical and vocational information will be analyzed to determine if rehabilitation services might help you return to work.

Once the initial review is completed by our rehabilitation program specialists working along with your doctor and other appropriate specialists, Prudential may elect to offer you and pay for a rehabilitation program. If the rehabilitation program is not developed by Prudential's rehabilitation program specialists, you must receive written approval from Prudential for the program before it begins.

The rehabilitation program may include, but is not limited to, the following services:

- coordination with your Employer to assist you to return to work;
- evaluation of adaptive equipment to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training;
- retraining for a new occupation; or
- assistance with relocation that may be part of an approved rehabilitation program.

If at any time, you decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that Prudential feels is appropriate for your disability and that has been approved by your Doctor, we will cease paying your monthly benefit.

Rehabilitation program means a program designed to assist you to return to work.

What Additional Benefits Are Payable When You Participate in a Rehabilitation Program ?

Prudential will send you a rehabilitation payment each month while you are:

- receiving long term disability benefits under the plan; and
- participating in a rehabilitation program that has been approved by Prudential.

The monthly rehabilitation payment is equal to 10% of your gross disability payment, up to a maximum of $1,000 per month. But if the monthly rehabilitation payment, together with your monthly payment, exceeds 100% of the maximum monthly benefit, your monthly rehabilitation payment will be reduced by the excess amount.

In addition, we will make monthly payments to you for up to 3 months after the date your disability ends, as long as you are:

- participating in a rehabilitation program that has been approved by Prudential; and
- not able to find employment.

This benefit may be paid in a lump sum.

How Can Prudential Help You With Day Care?

Prudential will send you a day care payment each month while you are:

- receiving long term disability benefits under the plan; and
- participating in a rehabilitation program that has been approved by Prudential.

The monthly day care payment is equal to the amount of your ***eligible day care expenses*** up to the maximum monthly day care amount.

Your maximum monthly day care amount is equal to the lesser of:

1. $250 times the number of ***eligible children***; and
2. $1,000.

Eligible day care expenses are the monthly expenses you incur for the day care of your eligible children that are:

- charged by a child-care provider who is not a member of your immediate family (i.e., you, your spouse, or a child, brother, sister or parent of you or your spouse);
- documented by receipts from the child-care provider which include the child-care provider's social security number or taxpayer identification number; and
- specified in the Prudential-approved rehabilitation program as needed in order for you to participate in the program.

Eligible children means your dependent children that are:

- age 14 or under; or
- incapable of providing their own care on a daily basis due to their own physical handicap or mental retardation.

Your children include your legally adopted children, and each of your stepchildren and foster children who live with you.

Long Term Disability Coverage

CLAIM INFORMATION

When Do You Notify Prudential of a Claim?

We encourage you to notify us of your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send Prudential written proof of your claim no later than 90 days after your elimination period ends. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.

The claim form is available from your Employer, or you can request a claim form from us. If you do not receive the form from Prudential within 15 days of your request, send Prudential written proof of claim without waiting for the form.

You must notify us immediately when you return to work in any capacity.

How Do You File a Claim?

You and your Employer must fill out your own section of the claim form and then give it to your attending doctor. Your doctor should fill out his or her section of the form and send it directly to Prudential.

What Information Is Needed as Proof of Your Claim?

Your proof of claim, provided at your expense, must show:

- That you are under the ***regular care*** of a ***doctor***.
- Appropriate documentation of your monthly earnings.
- The date your disability began.
- Appropriate documentation of the disabling disorder.
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation.
- The name and address of any ***hospital or institution*** where you received treatment, including all attending doctors.
- The name and address of any doctor you have seen.

For your Long Term Disability claim, we may request that you send proof of continuing disability, satisfactory to Prudential, indicating that you are under the regular care of a doctor. In some cases, you will be required to give Prudential authorization to obtain additional medical information, and to provide non-medical information (e.g., copies of your IRS federal income tax return, W-2's and 1099's) as part of your proof of claim, or proof of continuing disability. This proof, provided at your expense, must be received within 30 days of a request by us. Prudential will deny your claim or stop sending you payments if the appropriate information is not submitted.

Regular care means:

- you personally visit a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for your disabling condition(s) by a doctor whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

Doctor means a person who is performing tasks that are within the limits of his or her medical license; and

- is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Prudential will not recognize any relative including, but not limited to, you, your spouse, or a child, brother, sister, or parent of you or your spouse as a doctor for a claim that you send to us.

Hospital or institution means an accredited facility licensed to provide care and treatment for the condition causing your disability.

Who Will Prudential Make Payments To?

Prudential will make payments to you.

What Happens If Prudential Overpays Your Claim?

Prudential has the right to recover any overpayments due to:

- fraud;
- any error Prudential makes in processing a claim; and
- your receipt of deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Prudential will not recover more money than the amount we paid you.

What Are the Time Limits for Legal Proceedings?

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

How Will Prudential Handle Insurance Fraud?

Prudential wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Prudential promises to focus on all means necessary to support fraud detection, investigation and prosecution.

In some jurisdictions, if you knowingly and with intent to defraud Prudential, file an application or a statement of claim containing any materially false information or conceal for the purpose of misleading, information concerning any fact material thereto, you commit a fraudulent insurance act, which is a crime and subjects you to criminal and civil penalties. These actions will result in denial or termination of your claim, and, where such laws apply, are subject to prosecution and punishment to the full extent under any applicable law. Prudential will pursue all appropriate legal remedies in the event of insurance fraud.

Glossary

Active employment means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least 32 hours per week. If you are a partner or proprietor of the Employer, that work must be in the conduct of the Employer's business.

Your worksite must be:

- your Employer's usual place of business;
- an alternate work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation and jury duty are considered active employment.

Temporary and seasonal workers are excluded from coverage.

Individuals whose employment status is being continued under a severance or termination agreement will not be considered in active employment.

Annual enrollment period means a period each year when you may enroll for coverage or request a change for the following calendar year. Your Employer will notify you of when this Annual Enrollment Period begins and ends.

Benefit waiting period means the continuous period of time that you must be in a covered class before you are eligible for coverage under a plan. The period must be agreed upon by the Employer and Prudential.

Change in status means a change in status as defined in the regulations under Internal Revenue Code section 125, unless your Employer's cafeteria plan document or human resource policy contains more restrictive provisions. In that event, your Employer may restrict the situations where you can change your coverage.

Confined or confinement for this section means a hospital stay of at least 8 hours per day.

Contract holder means HCA MANAGEMENT SERVICES, LP ON BEHALF OF THE PLAN ADMINISTRATION COMMITTEE, to whom the Group Contract is issued.

Covered class means your class as determined by the Contract Holder. This will be done under the Contract Holder's rules, on dates the Contract Holder sets. The Contract Holder must not discriminate among persons in like situations. You cannot belong to more than one class for insurance on each basis, Contributory or Non-contributory Insurance, under a plan. "Class" means covered class, benefit class or anything related to work, such as position or earnings, which affects the insurance available. If you are an employee of more than one Employer included under the Group Contract, for the insurance you will be considered an employee of only one of those Employers. Your service with the others will be treated as service with that one.

Deductible sources of income means income from deductible sources listed in the plan that you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

Disability earnings means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your greatest extent possible as explained in the plan.

Salary continuance paid to supplement your disability earnings will not be considered payment for work performed.

Doctor means a person who is performing tasks that are within the limits of his or her medical license; and

- is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Prudential will not recognize any relative including but not limited to you, your spouse, or a child, brother, sister, or parent of you or your spouse as a doctor for a claim that you send to us.

Eligible children (Day Care) means your dependent children that are:

- Age 14 or under; or
- Incapable of providing their own care on a daily basis due to their own physical handicap or mental retardation.

Your children include your legally adopted children, and each of your stepchildren and foster children who live with you.

Eligible day care expenses are the monthly expenses you incur for the day care of your eligible children that are:

- charged by a child-care provider who is not a member of your immediate family (i.e., you, your spouse, or a child, brother, sister or parent of you or your spouse);
- documented by receipts from the child-care provider which include the child-care provider's social security number or taxpayer identification number; and
- specified in the Prudential-approved rehabilitation program as needed in order for you to participate in the program.

Eligible survivor means your spouse, if living; otherwise, your children under age 25.

Elimination period (LTD) means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Prudential. If you become covered under a group long term disability plan that replaces this plan during your elimination period, your elimination period under this plan will not be met.

Employee means a person who is in active employment with the Employer for the minimum hours requirement.

Employer means Employers who are HCA Inc.'s subsidiaries or affiliates.

Evidence of insurability means a statement of your medical history which Prudential will use to determine if you are approved for coverage.

Gainful occupation, if you enrolled for Option 2 or Option 3, means an occupation, including self employment, that is or can be expected to provide you with an income within 12 months of your return to work, that exceeds:

- 80% of your indexed monthly earnings, if you are working; or
- 60% of your monthly earnings, if you are not working.

Gross disability payment means the benefit amount before Prudential subtracts deductible sources of income and disability earnings.

Hospital or institution means an accredited facility licensed to provide care and treatment for the condition causing one's disability.

Indexed monthly earnings means your monthly earnings as adjusted on each July 1 provided you were disabled for all of the 12 months before that date. Your monthly earnings will be adjusted on that date by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-W) is published by the U.S. Department of Labor. Prudential reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W.

Indexing is only used to determine your percentage of lost earnings while you are disabled and working.

Injury means a bodily injury that:

- is the direct result of an accident;
- is not related to any cause other than the accident; and
- results in immediate disability.

Disability must begin while you are covered under the plan.

Insured means any person covered under a coverage.

Law, plan or act means the original enactment of the law, plan or act and all amendments.

Leave of absence means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by the Contract Holder, other than for reasons in connection with any severance or termination agreement. Your normal vacation time or any period of disability is not considered a leave of absence.

Material and substantial duties means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

Maximum monthly benefit means the maximum benefit amount for which you are insured under this plan as shown in the Benefits Highlights.

Maximum period of payment means the longest period of time Prudential will make payments to you for any one disability.

Mental illness means a psychiatric or psychological condition regardless of cause. Mental illness includes but is not limited to schizophrenia, depression, manic depressive, or bipolar illness, anxiety, somatization, and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine. But mental illness does not include substance related disorders.

Monthly earnings means your gross monthly income from your Employer as defined in the plan.

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

Monthly payment means your payment after any deductible sources of income have been subtracted from your gross disability payment.

Part-time basis (LTD) means the ability to work and earn 20% or more of your indexed monthly earnings.

Payable claim means a claim for which Prudential is liable under the terms of the Group Contract.

Plan means a line of coverage under the Group Contract.

Recurrent disability means a disability which is:

- caused by a worsening in your condition; and
- due to the same cause(s) as your prior disability for which Prudential made a Long Term Disability payment.

Reduced hours means you are working less than the number of hours required to be considered in active employment.

Regular care means:

- one personally visits a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat one's disabling condition(s); and
- one is receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for one's disabling condition(s) by a doctor whose specialty or experience is the most appropriate for one's disabling condition(s), according to generally accepted medical standards.

Regular occupation means the occupation you are routinely performing when your disability begins. Prudential will look at your occupation as it is normally performed in the national economy instead of how the work tasks are performed for a specific employer or at a specific location. An occupation that provides you with less than 60% of your monthly earnings is not considered your regular occupation.

Rehabilitation program means a program designed to assist you to return to work.

Retirement plan means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions.

Salary continuation or accumulated sick leave (LTD) means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Group Contract. This continued payment must be part of an established plan maintained by your Employer for the benefit of an employee covered under the Group Contract. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account as such, in calculating your monthly payment.

Sickness means any disorder of your body or mind, but not an injury. Sickness includes pregnancy, abortion, miscarriage, childbirth, and any complication related to pregnancy. Disability must begin while you are covered under the plan.

Substance related disorders means alcoholism or the non-medical use of narcotics, sedatives, stimulants, hallucinogens or any other such substance.

Temporary layoff means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by the Contract Holder, other than for reasons in connection with any severance or termination agreement. Your normal vacation time, any period of disability or FMLA leave is not considered a temporary layoff.

We, us, and our means The Prudential Insurance Company of America.

You means a person who is eligible for Prudential coverage.

This ERISA Statement

is not part of the

Group Insurance Certificate.

ERISA STATEMENT

Plan Benefits Provided by

The Prudential Insurance Company of America
751 Broad Street
Newark, New Jersey 07102

This Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under your Employer's ERISA plan(s). For all purposes of this Group Contract, the Employer/Policyholder acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer/Policyholder be deemed the agent of The Prudential Insurance Company of America, absent a written authorization of such status executed between the Employer/Policyholder and The Prudential Insurance Company of America. Nothing in these documents shall, of themselves, be deemed to be such written execution.

The Prudential Insurance Company of America as Claims Administrator has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious.

Claim Procedures

1. Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

(a) the specific reason(s) for the denial,

(b) references to the specific plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals, and

(e) if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

2. Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

(a) the specific reason(s) for the adverse determination,

(b) references to the specific plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and

(f) a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Rights and Protections

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HCA HEALTH AND WELFARE BENEFITS PLAN

Effective January 1, 2010

HCA HEALTH AND WELFARE BENEFITS PLAN

Table of Contents

HCA HEALTH AND WELFARE BENEFITS PLAN

Effective as of January 1, 2010, HCA Inc. (the "Company") hereby establishes a new plan for health and welfare benefits through a merger and consolidation of the welfare benefits described below in this preamble and in Article II.

BACKGROUND AND PURPOSE

A. Background.

1. ***Prior Plans.*** Prior to January 1, 2010, the Company maintained separate group welfare and fringe benefit plans for the benefit of its eligible employees, including the: (i) Medical Plan, (ii) Life, Accidental Death & Dismemberment Plan, (iii) Dental Plan, (iv) Flexible Benefits Plan, (v) Long Term Disability Plan, (vi) Employee Assistance Program, and (vii) Core Trust Voluntary Benefits Plan ("Prior Plans").

2. ***Consolidation.*** Effective as of January 1, 2010, the Company has terminated the Prior Plans and established a new plan for all of the benefits from the Prior Plans listed above in Paragraph 1(i)-(vii). The new plan is the HCA Health and Welfare Benefits Plan.

3. ***Separate ERISA Plans.*** The Company also maintains the Employee Health and Safety Plan, the Retiree Medical Plan and the Severance Allowance Plan. However, these plans will remain separate ERISA plans from the HCA Health and Welfare Benefits Plan (the "Plan").

B. Purpose. The primary purpose of the Plan is to make available to eligible employees of the Company and its participating affiliates the benefit programs that are included within the Plan.

C. Contributions. Some of the benefit programs under the Plan are provided and paid for solely by the Company and its participating affiliates. Others are contributory and paid in whole or in part by eligible employees. To the extent permissible, employee contributions will be made on a pre-tax basis through the cafeteria plan included in the Plan, and all other employee contributions will be made on an after-tax basis.

D. Plan Document. The Plan document is comprised of this Plan document and, with respect to each benefit program included within the Plan, the summary plan description(s) applicable to that benefit program.

E. Type of Plan. The Plan and each of the benefit programs under the Plan (other than the cafeteria plan, the dependent care flexible spending account, automobile insurance, homeowners insurance and any other non-ERISA benefits) are welfare benefits under Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The cafeteria plan is established under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"), and the dependent care flexible spending account benefit program is established under Code Section 129.

STATEMENT OF PLAN

To establish and adopt the Plan with the purposes and goals as hereinabove described, the Company hereby sets forth the terms and provisions as set forth below in this document.

ARTICLE I
DEFINITIONS

The following words and phrases, when used with an initial capital letter, shall have the meanings below unless the context clearly indicates otherwise, except as otherwise provided in the Summary Plan Descriptions. Plan terms defined in the Summary Plan Descriptions are incorporated by reference.

1.1 Affiliate means an entity (other than the Company) which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Company, any trade or business which is under common control (as defined in Code Section 414(c)) with the Company, any organization which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Company, any other entity required to be aggregated with the Company pursuant to regulations under Code Section 414(o), or pursuant to regulations issued under Code Section 125.

1.2 After-Tax Benefits means cash and the Benefit Programs listed as after-tax in the Summary Plan Descriptions and Appendix D, as may be provided and/or made available for purchase by Employees on an after-tax basis under this Plan.

1.3 Annual Enrollment Period means the open enrollment period, as established by the Company and indicated in the open enrollment materials each year, during which all Eligible Employees may enroll in the Plan and select the Benefit Programs in which to participate for the succeeding Plan Year.

1.4 Benefits Appeals Committee means the Benefits Appeals Committee created by the Company to review appeals of denied Claims after the first level of review.

1.5 Benefits Contributions means the amount contributed by a Participant to pay for the cost of the Participant's selected Benefit Programs.

1.6 Benefits Oversight Committee means the Benefit Oversight Committee created by the Company to perform certain non-fiduciary functions with respect to the Plan.

1.7 Benefits Programs means the various welfare and fringe benefits made available to Participants under this Plan.

1.8 Cash-Out Dollars means the taxable dollar amounts that the Participating Companies provide if participation in certain Benefit Programs is waived pursuant to Section 5.4.

1.9 Claim means any request for participation in, coverage under, or payment or reimbursement of, a benefit under the Plan, which request is made in accordance with the Plan's claims review procedures described in Article V.

1.10 Claims Fiduciary means an individual or entity, designated in the Plan (including the Summary Plan Description, Insurance Contracts or appendices, which are part of the Plan) or otherwise appointed by the Plan Administration Committee, to have final discretionary authority

to interpret the terms of the Plan and decide questions of fact, as necessary to make a determination as to whether the Claims presented to the Claims Fiduciary are payable, in whole or in part, in accordance with the terms of the Plan. For the insured Benefit Programs, the insurance company is the Claims Fiduciary and "named fiduciary." For self-funded Benefit Programs, the Claims Fiduciary shall be the "named fiduciary" responsible for determining the first appeal of denied claims, and the Benefits Appeals Committee is the Claims Fiduciary for any subsequent appeals.

1.11 COBRA Continuation Coverage means the elected continuation of coverage pursuant to the provisions of Section 601, *etc. seq.* of ERISA, Code Section 4980B and Article VI of this Plan.

1.12 Code means the Internal Revenue Code of 1986, as amended.

1.13 Company means HCA Inc. and its successors.

1.14 Company Contribution means any amount the Company or a Participating Company may contribute on behalf of each Participant towards the cost of Benefit Programs for the Participant and his or her Dependents under the Plan.

1.15 Company-Paid Benefit Programs means the Benefit Programs, if any, listed in the Summary Plan Descriptions and Appendix D that a Participating Company may provide to an Eligible Employee without regard to whether the Eligible Employee does or does not enroll in that Benefit Program under the Plan.

1.16 Compensation except as otherwise provided in an applicable appendix or Summary Plan Description means the total cash wages or salary paid to an Employee by a Participating Company in each Plan Year reportable on IRS Form W-2, including the amount (if any) of elective amounts that are not includible in the gross income of the Employee under Code Sections 125, 132(f) and 401(k). The definition of "Compensation" may vary for purposes of each Benefit Program and the Plan Administrator, in its sole discretion, may use a different Compensation determination date for each Benefit Program.

1.17 Compensation Reduction Agreement means a voluntary agreement under which an Employee agrees that the amount of his or her cash Compensation for the Plan Year (or applicable portion of the Plan Year) shall be reduced for the purpose of obtaining one or more Pre-Tax Benefits or After-Tax Benefits offered by the Plan. An Eligible Employee or Participant shall enter into or may be deemed to enter into a Compensation Reduction Agreement when enrolling in the Plan and during any Enrollment Period, as provided in this document or in the Summary Plan Descriptions. A Compensation Reduction Agreement may be entered into when an Employee or Participant enrolls in the Plan by writing, electronic or telephonic means, as is deemed acceptable by the Plan.

1.18 Contract means an agreement between any Participating Company and any third party administrator relating to the provision of Benefit Programs for one or more Covered Persons.

1.19 Covered Person means a Participant and/or his or her Enrolled Dependents, whichever is applicable.

1.20 Day Care FSA Benefit Program means the Day Care Flexible Spending Account Benefit Program described in Appendix A.

1.21 Dependent means an individual, other than an Eligible Employee, who is eligible to participate in the Plan based on the individual's relationship to an Eligible Employee and on the terms of the Summary Plan Descriptions; provided, in the case of a divorced Eligible Employee: (a) for purposes of accident or health coverage, a child shall be considered a dependent of both parents to the extent the child lives with one or both parents and one or both parents provide over half of the child's support; and (b) if a Participant's Spouse is also an Employee, a child can be covered under a Benefit Program as a Dependent of either Eligible Employee but not both.

1.22 Effective Date means January 1, 2010, the effective date of this Plan.

1.23 Eligible Employee means an Employee who is eligible to participate in one or more of the Benefit Programs in accordance with the terms of the Summary Plan Descriptions or a former Employee who terminates pursuant to a written severance agreement and receives benefits under the Plan in accordance with the terms of each such written severance agreement. An Eligible Employee does not include:

(a) An Employee who is a leased employee within the meaning of Code Section 414(n);

(b) An individual classified as an independent contractor, temporary employee, seasonal employee, independent contractor, or leased employee under a Participating Company's customary worker classification practices (whether or not the individual is actually an Employee or reclassified as an Employee by the Internal Revenue Service or a court of competent jurisdiction);

(c) An Employee who is included in a unit of Employees covered by a collective bargaining agreement between employee representatives and one or more Participating Companies, unless the bargaining agreement expressly provides that coverage is provided under the Plan for Employees in the bargaining unit who meet the eligibility requirements in the Summary Plan Descriptions, and the applicable collective bargaining agreement is in effect at the time an Employee otherwise becomes eligible under this Plan;

(d) An Employee who is a nonresident alien and who receives no earned income from an Affiliate that is U.S. source income;

(e) Employees covered under welfare plan maintained by a foreign Affiliate; or

(f) Employees who waived participation in the Plan through any means, including individuals whose employment is governed by a written agreement with a

Participating Company (including an offer letter setting forth the terms and conditions of employment) that provides that the individual is not eligible to participate in the Plan.

1.24 Employee means an individual who is a common law employee of a Participating Company.

1.25 Enrolled Dependent means, for a specified period, each of the Dependents whom a Participant has elected to cover under the Plan as his or her Dependent during such period.

1.26 Enrollment Period means the Initial Enrollment Period and the Annual Enrollment Period during which Eligible Employees make their Benefit Programs elections.

1.27 ERISA means the Employee Retirement Income Security Act of 1974, as amended.

1.28 FMLA means the Family and Medical Leave Act of 1993, as amended.

1.29 HAF Eligible Participant means a Participant who (i) qualifies for assistance from the Company through the Health Assistance Fund; and (ii) has elected to receive the Company's assistance though the Health Assistance Fund.

1.30 Health Assistance Fund means the fund established by the Company to assist HAF Eligible Participants with Benefit Contributions.

1.31 Health Benefit Options means the Benefit Programs that provide medical care (as that term is defined in 42 U.S.C. 300 gg-91(a)(2)).

1.32 Health Care FSA Benefit Program means the Health Care Flexible Spending Account Benefit Program as described in Appendix B.

1.33 HIPAA means Health Insurance Portability and Accountability Act of 1996.

1.34 HMO means a Health Maintenance Organization.

1.35 Individual means any person who is the subject of health information created, received or maintained by the Plan or Company.

1.36 Initial Enrollment Period means the period during which a newly Eligible Employee may enroll in the Plan and make Benefit Program elections for the remaining portion of the Plan Year, as set forth in the Summary Plan Descriptions.

1.37 Insurance Contract means an agreement between a Participating Company and an Insurer pursuant to which the Insurer agrees to provide a Benefit Program and to pay benefits, pursuant to a policy issued by the Insurer to the Participating Company in accordance with applicable state law in consideration for the payment of premiums. For purposes of this Plan document, the "Insurance Contract" includes the insurance policy. If there is conflict between

this Plan document and the Insurance Contract, the Insurance Contract controls with regard to the Benefit Program provided under the Insurance Contract.

1.38 Insurer means any insurance company or HMO licensed to do business in a state in accordance with applicable state law with which a Participating Company has entered into an Insurance Contract.

1.39 Organized Health Care Arrangement means the relationship of separate legal entities as defined in 45 C.F.R. §160.103.

1.40 Participant means an Eligible Employee who has completed (or is deemed to have completed) the election procedures provided in the Summary Plan Descriptions or who is an Eligible Employee participating in a Company Paid Benefit.

1.41 Participating Company means the Company and any Affiliate that the Benefits Oversight Committee has authorized to participate in the Plan, either by resolution or by permitting Eligible Employees of an Affiliate to enroll in the Plan, unless the Affiliate is otherwise specifically excluded in the Summary Plan Descriptions or Appendix C to this Plan. As may be indicated in Appendix C, an Affiliate may be a Participating Company with regard to certain Benefit Programs but not others, and may begin participating in different Benefit Programs at different times. Likewise, different Eligible Employees may be eligible for different Benefit Programs and may begin participating in different Benefit Programs at different times.

1.42 Plan means the HCA Health and Welfare Benefits Plan.

1.43 Plan Administration Committee means the committee described in as described in Article VIII.

1.44 Plan Administrator means the plan administrator (as that term is defined under ERISA). The Plan Administration Committee or its designee(s) shall serve as the Plan Administrator, unless another individual or entity is designated by the Company.

1.45 Plan Year means the 12-month calendar period beginning on each January 1 and ending on the subsequent December 31.

1.46 Pre-Tax Benefits means the Benefit Programs listed as pre-tax in the Summary Plan Descriptions and Appendix D, as may be provided and/or made available for purchase by Employees on a pre-tax basis under the Plan.

1.47 Privacy Notice means the notice of the Plan's privacy practices distributed to Plan participants in accordance with 45 C.F.R. § 164.520, as amended from time to time.

1.48 Privacy Official means the individual designated in accordance with Section 9.8 of the Plan.

1.49 Protected Health Information (PHI) means individually identifiable health information as defined in 45 C.F.R. § 160.103.

1.50 Qualified Medical Child Support Order (QMCSO) means an order as described in Section 10.6.

1.51 Security Incident means an incident as defined in 45 C.F.R. §164.304.

1.52 Security Official means the individual designated in accordance with Section 9.8 of the Plan.

1.53 Spouse means an individual who is the opposite gender of the Employee and who is legally married to the Employee in accordance with state law, including a common law spouse, to the extent consistent with the Federal Defense of Marriage Act.

1.54 Summary Plan Descriptions means the documents that describe the substantive provisions of the Benefit Programs as required by ERISA Section 102 and the documents used to describe the Day Care FSA Benefit Program.

ARTICLE II
PLAN STRUCTURE

2.1 Type of Plan. The Plan is an ERISA welfare benefit plan and a Code Section 125 cafeteria plan. The Plan, as set forth in its entirety in this document, provides the terms and conditions controlling the Benefit Programs provided under this Plan.

2.2 Welfare Benefit Plan. The welfare benefit portion of the Plan offers the Benefit Programs set forth in Appendix D. The Benefit Programs offered under the welfare benefit portion of this Plan may be self-funded by the Company or provided through insurance, as set forth in Appendix D.

2.3 Cafeteria Plan. The cafeteria plan portion of the Plan offers each participant the opportunity to elect, in lieu of a portion of regular cash compensation, coverage under any of the qualified benefits listed in Appendix D or to elect to receive all compensation in the form of cash and to forgo any such coverage. Certain Benefit Programs are not part of the cafeteria plan even though they may be described in this Plan document as part of the welfare benefit plan.

2.4 Plan Document and Summary Plan Descriptions.

(a) Welfare Benefit Plan. The plan document for each of the Benefit Programs offered under a welfare benefit portion of this Plan is this Plan document and the Summary Plan Description applicable to that Benefit Program. For each insured Benefit Program, the Insurance Contract for that Benefit Program serves as the official Plan document. To the extent there is any conflict between the terms of this Plan and the Insurance Contracts, the Insurance Contracts shall control.

(b) Cafeteria Plan. The plan document for the cafeteria plan is this Plan document and the portion of the Summary Plan Descriptions describing the Change in Status Events, which are expressly incorporated into the cafeteria plan portion of this Plan by reference.

(c) Day Care FSA Benefit Program. The Day Care FSA Benefit Program is intended to qualify as a dependent care assistance program under Code Section 129. Although included in this document, the Day Care FSA Benefit Program is not subject to ERISA, and is a separate plan for purposes of administration and nondiscrimination requirements imposed by Code Section 129.

(d) Health Care FSA Benefit Program. The Health Care FSA Benefit Program is intended to qualify as a self-insured medical reimbursement plan under Code Section 105. Although included in this document, the Health Care FSA Benefit Program is a separate plan for purposes of administration and nondiscrimination requirements imposed by Code Section 105. The Health Care FSA Benefit Program is also a separate plan for purposes of COBRA and applicable portability provisions of HIPAA.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

Except as otherwise indicated in the Summary Plan Descriptions, the following provisions govern eligibility and participation:

3.1 Commencement of Participation. Each Eligible Employee who satisfies the eligibility requirements provided in the Summary Plan Descriptions with respect to one or more Benefit Programs shall be eligible to participate in the Plan as of the eligibility dates provided in such Summary Plan Descriptions. Eligible Employees shall only receive Company-Paid Benefits (if any) until the time that he or she makes an election to participate in a Benefit Program and such election becomes effective.

3.2 Enrolled Dependent's Commencement of Participation. Except as otherwise provided in the Summary Plan Descriptions, coverage for an Enrolled Dependent will begin on the same date that coverage begins for the Participant who elects the Dependent coverage or a later date as described in the Summary Plan Descriptions.

3.3 Proof of Dependent Status. The Plan Administrator may periodically request proof of Dependent status for each Benefit Program in which a Dependent may participate. Failure to provide satisfactory proof may result in termination of dependent coverage in each applicable Benefit Program. The termination may be retroactive to the date the first benefit from the applicable Benefit Program was paid. The Plan Administrator reserves the right to require the Participant to reimburse the Plan for any benefits paid under a Benefit Program for an otherwise ineligible Dependent.

3.4 Reinstatement of Former Participant. If a former Employee returns to active employment as an Eligible Employee and elects to participate in Benefit Programs under the Plan, he or she will be reinstated as a Participant in such Benefit Programs as provided in the Summary Plan Descriptions. Eligible Employees shall only receive Company-Paid Benefits (if any) until the time that he or she makes an election to participate in a Benefit Program and such election to participate in a Benefit Program becomes effective.

3.5 Cessation of Participation. An individual will cease to be a Covered Person with respect to some or all Benefit Programs, and all such Benefit Program coverage shall terminate, on the earliest of the dates provided in the Summary Plan Descriptions.

3.6 Qualifying Leave Under the FMLA. Notwithstanding any provision to the contrary in this Plan, if a Participant goes out on a qualifying FMLA leave, the Participant will be entitled to continue the Participant's Benefit Programs that provide group health coverage (as defined in the FMLA) on the same terms and conditions as though the Participant were still active, all to the extent required by FMLA. The requirements for continuing coverage, procedures for FMLA leave and payment option(s) provided by the Company are explained in the Summary Plan Descriptions.

3.7 Non-FMLA Leaves of Absence. If a Participant goes on a non-FMLA Leave of Absence that does not affect eligibility for Benefit Programs, then the Participant will continue to participate, and the Benefit Contributions due for the Participant's coverage will be paid by one

or more of the payment options described in the Summary Plan Descriptions and implemented by the Company on a uniform and consistent basis in accordance with the Company's internal policy and procedure. If the Participant goes on a leave of absence that affects eligibility for Benefit Programs, the election change rules described in the Summary Plan Descriptions will apply. If the policy requires coverage to continue during the leave but permits a Participant to discontinue contributions while on the leave of absence, the Participant will, upon returning from leave of absence, be required to repay the contributions not paid by the Participant during the leave of absence.

ARTICLE IV
ELECTIONS

4.1 Election of Benefit Contributions. A Participant may elect any combination of Pre-Tax Benefits and After-Tax Benefits (to the extent indicated in the enrollment materials) available under the Plan; provided, only benefits excluded from the Participant's taxable income under Chapter 1 of the Code (other than Section 106(b), 117, 124, 127, or 132 and any other benefit permitted by the Code (*e.g.*, any group-term life insurance coverage that is includible in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Section 79)), may be funded on a pre-tax basis. Long-term care insurance and Spouse and Dependent life and accidental death dismemberment insurance, however, may not be funded on a pre-tax basis. The Company, in its sole discretion, may contribute Company Contributions on behalf of each Participant to provide Benefit Programs to the Participant and his or her Dependents, if applicable, under the Plan.

4.2 Pre-Tax Benefits. To the extent that a Participant elects Pre-Tax Benefits (as permitted under the terms of the Plan with respect to such Benefit Programs), the Compensation Reduction Agreement is the agreement under which the Participant's taxable Compensation for the applicable period is reduced in an amount equal to the Employee's Benefit Contributions for the Pre-Tax Benefits before the application of applicable state, local, and federal taxes (where permitted by law). The Pre-Tax Benefits are listed in the Summary Plan Descriptions and Appendix D.

4.3 After-Tax Benefits. To the extent that a Participant selects After-Tax Benefits, the Compensation Reduction Agreement is the agreement where the Employee requests, and the Participating Company agrees, to make payments to this Plan on a payroll deduction basis in an amount equal to the Employee's Benefit Contributions for the After-Tax Benefits (less any applicable Company Contributions) after all applicable state, local and federal taxes have been deducted. The After-Tax Benefits are listed in the Summary Plan Descriptions and Appendix D.

4.4 Current Participants. Each Eligible Employee who was a Participant in the Prior Plans immediately before the establishment of this Plan shall become a Participant in this Plan on the Effective Date.

4.5 Initial Enrollment Period.

(a) New Employees and Employees Who Have Not Yet Satisfied the Plan's Waiting Period. An Employee who becomes an Eligible Employee after the Effective Date will become a participant in the Company-Paid Benefit Programs as set forth in the Summary Plan Descriptions. For the Benefit Programs other than the Company-Paid Benefit Programs, an Employee who becomes an Eligible Employee after the Effective Date, must complete and submit a Compensation Reduction Agreement with the Plan Administrator or its designated third party administrator during the Initial Enrollment Period. Participation will commence in the various Benefit Programs under this Plan as provided in the Summary Plan Descriptions.

(b) Failure to Elect. An Eligible Employee who fails to complete and submit a Compensation Reduction Agreement in accordance with paragraph (a) during an Initial

Enrollment Period will be deemed to have elected to participate in certain Benefit Programs under this Plan as provided in the Summary Plan Descriptions.

4.6 Annual Enrollment Period. Each Eligible Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan shall be notified before each Plan Year of his right to continue as, or become, a Participant in this Plan, and shall be given a reasonable period of time in which to exercise this right during the Annual Enrollment Period. The date on which the Annual Enrollment Period commences and ends will be indicated in the Summary Plan Descriptions or the enrollment materials. An election is made during the Annual Enrollment Period in the manner described in the Summary Plan Descriptions. The consequences of failing to make an election during the Annual Enrollment Period will be explained in the Summary Plan Descriptions. Notwithstanding any other provision of this Section, each Participant (and an Employee who is expected to become a Participant at the beginning of the Plan Year) who is a member of a collective bargaining unit that is engaged in labor negotiations with the Company or a Participating Company does not have to receive an opportunity to make elections for Benefit Programs for as long as (i) the individual's elections under the Plan in effect immediately prior to the beginning of such negotiations are continuing, (ii) such negotiations are continuing and are expected to continue past the beginning of the upcoming Plan Year, and (iii) no impasse has occurred in such negotiations.

4.7 Change of Elections. A Participant shall not make any changes to any amount withheld from the Participant's Compensation pursuant to a Compensation Reduction Agreement for Pre-Tax Benefits, or, where applicable, to the Participant's elected allocation of Company Contributions, except for: (i) changes made during the Annual Enrollment Period, (ii) changes caused by termination of employment or cessation of eligibility, and (iii) changes pursuant to the FMLA, and (iv) under the change in status event rules stated in the Summary Plan Descriptions. Changes to after-tax elections may be permitted under the terms of the Summary Plan Descriptions or Insurance Contract. Except as provided in the Summary Plan Descriptions for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child, all payroll deductions shall be effective on a prospective basis only (*e.g.*, payroll deductions for Pre-Tax Benefit election changes will become effective no earlier than the first day of the first pay period the election change was filed). Coverage under the Benefit Program will commence as indicated in the Summary Plan Descriptions. Election changes may become effective later to the extent the coverage in the applicable Benefit Program commences later as determined by the Plan Administrator.

4.8 Impact of Termination of Employment on Election or Cessation of Eligibility. Termination of employment or cessation of eligibility shall automatically revoke any Compensation Reduction Agreement. Except as provided above, if revocation occurs under this Section 4.8, no new election with respect to Pre-Tax Benefits may be made by the Participant during the remainder of the Plan Year except as provided in the Summary Plan Descriptions.

4.9 Nondiscrimination Requirements. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for the Plan Year any nondiscrimination requirement imposed by the Code, the Plan Administrator may take any action as it deems appropriate, under rules uniformly applicable to similarly situated Participants, to ensure compliance with the requirement or limitation. This action may include, without limitation, a

modification of elections by highly compensated individuals or key employees (as defined by the Code) without their consent.

ARTICLE V
CONTRIBUTIONS, BENEFITS AND CLAIMS

Except as otherwise provided in the Summary Plan Descriptions, the following provisions shall apply to the Plan Benefit Programs:

5.1 Source of Benefit Funding. The cost of coverage for Benefit Programs shall be funded by the Participant's Pre-Tax or After-Tax Benefit Contributions and/or any Company Contributions. The Plan Administrator shall establish the Benefit Contributions for each Benefit Program and deadlines for making such Benefit Contributions. The Benefit Contributions for each Benefit Program will be communicated to Eligible Employees and expressed as a flat dollar amount. The maximum amount of Pre-Tax Benefit Contributions, plus any Company Contributions made available by the Company, shall not exceed the total cost of the Benefit Program elected. To the extent that a Participant does not elect to have the maximum amount of his Compensation contributed as Pre-Tax or After-Tax Benefit Contributions, the amount not elected shall be paid to the Participant in the form of normal Compensation payments; provided, any applicable Company Contributions may not be received in the form of cash compensation, except as otherwise provided in the Summary Plan Descriptions or enrollment materials.

5.2 Company Contributions. The amount of the Company Contribution shall be calculated for each Plan Year based upon reasonable factors set by the Company in its sole discretion (unless provided otherwise under the terms of the Plan with respect to any Benefit Program). Except as otherwise indicated in the enrollment materials or Summary Plan Descriptions, in no event will any Company Contribution be disbursed to a Participant even if the cost of Benefit Programs elected is less than the total stated amount of Company Contribution allocable to the Participants; any excess will be retained by the Company and/or other Participating Companies.

5.3 Health Assistance Fund. The Company may provide additional contributions to HAF Participants through the Health Assistance Fund. The Company, in its sole discretion, shall determine:

(a) the Benefit Programs eligible for funding through the Health Assistance Fund;

(b) Participants eligible for assistance from the Health Assistance Fund; and

(c) Benefits Contributions, if any, for HAF Participants.

Notwithstanding any Plan provision to the contrary, no contribution will be required by a HAF Participant to purchase the lowest priced, Employee only benefit option available to such HAF participant under the Medical Benefit Program.

5.4 Cash-Out Dollars. The Company or a Participating Company may, in its sole discretion, provide that if participation in a certain Benefit Program is waived, the Participant shall receive Cash-Out Dollars during the Plan Year in the form of taxable cash compensation. The amount of Cash-Out Dollars that will be available to the Participant as a taxable benefit under the Plan will be determined on a year-by-year basis by the Participating Company in its sole discretion. The amount of the Company Contribution for the purchase of certain Benefit

Programs may be different than the amount of Cash-Out Dollars that may be received as a taxable benefit for the same Benefit Program for the same Plan Year, as determined by the Participating Company.

5.5 Provision of Benefits. A Participating Company shall provide any Company-Paid Benefit Programs and the Benefit Programs the Participant has elected under the Plan in accordance with this document, the Summary Plan Descriptions, Contract, and any conditions or restrictions imposed by an Insurer providing any Benefit Program under an Insurance Contract.

5.6 Insurance Contracts. To the extent the Benefit Programs are funded by the Participating Company, any dividends, retroactive rebates, or other refunds or credits that may become payable under any Insurance Contract, health care service contracts or benefit programs shall be the property of and retained by the appropriate Participating Company.

5.7 Cancellation of Benefit Programs for Failure to Pay Benefit Contributions. Coverage shall be cancelled upon a Participant's failure to pay the Benefit Contributions for the Benefit Programs selected as provided in the Summary Plan Descriptions and Insurance Contracts. The Participant and any Enrolled Dependents shall not be entitled to reimbursement of any Pre-Tax Benefits' or After-Tax Benefits' claims that are incurred after the effective date of the cancellation for nonpayment, as stated in the Summary Plan Descriptions and Insurance Contracts.

5.8 Claims. Except as otherwise provided in the Summary Plan Descriptions or Insurance Contract:

(a) Claims payments with respect to Benefit Programs under this Plan shall be made only with respect to Claims or expenses incurred on or after the date an individual first becomes a Covered Person, and before the date the Covered Person ceases to be eligible for the Benefit Programs. A Claim or expense for a Benefit Program shall be deemed to be incurred when the Covered Person is provided with the service that gives rise to the expense, not when the Covered Person is billed or charged for the service.

(b) All Claims for Benefit Programs under the Plan shall be made, processed and paid in accordance with the terms and conditions of the Summary Plan Descriptions and Insurance Contract for the Benefit Program. With respect to any self-funded Benefit Program provided under this Plan, a Covered Person's failure to cash a Benefit Program check within 24 months of issuance of the payment shall result in the outstanding check being voided and a forfeiture of the payment to the Plan.

(c) A Covered Person or other claimant shall be entitled to reimbursement or payment only if he (or his estate) applies for the reimbursement or payment on or before the date that is 24 months following the date the Claim with respect to the Benefit Program was incurred or if different than this paragraph (c), as set forth in the applicable Insurance Contract or Summary Plan Descriptions or under the Medicare secondary payer provisions of the Social Security Act.

5.9 Claims Procedure and Appeal of Benefit Denials. The process by which a Participant may file a Claim for benefits, and the process by which a Participant may appeal the

denial of a Claim for Benefits are set forth in the Summary Plan Descriptions or Insurance Contract and incorporated into this document by reference. As provided in the Summary Plan Descriptions, insurance carriers (and other entities) may serve as the Claims Fiduciary with regard to certain benefits.

5.10 Suits for Benefits. A claimant is not entitled to take legal action in federal court until he or she has exhausted the appeals procedures in the Summary Plan Descriptions or Insurance Contract provisions that apply to the Benefit Program. If the benefits are provided under an Insurance Contract, a Claimant must take all legal action pertaining to a Claim within the time limits in the Insurance Contract. For all other Claims (including those under an Insurance Contract that does not provide for a time limit to file suit), a claimant must take all legal action pertaining to a Claim within the earliest of the following dates except to the extent different time periods have been established in the Summary Plan Descriptions:

(a) one year after the date the Claims Fiduciary has made a final determination of the Claim or appeal in accordance with the applicable claims review procedures or should have been made in accordance with the Plan's Claims review procedures; or

(b) two years after the date the service or treatment was rendered.

If there is a conflict between this Section 5.10 and the Insurance Contract, the Insurance Contract will control.

5.11 Errors. An administrative or clerical error when determining eligibility, benefits or maintaining Plan records shall not place in force any coverage or benefits not provided for under the Plan, void any valid coverage or benefits provided under the Plan, or extend any coverage or benefit that has otherwise terminated. When an administrative or clerical error becomes known, the Plan Administrator shall cause all proper and equitable adjustments to be made, including any adjustment to any required Benefit Contributions as necessary to correct the error.

In no event shall (i) the Plan Administrator or other fiduciary of the Plan, (ii) the Company or any Participating Company, or (iii) the Benefits Oversight Committee be liable in any manner for any administrative or clerical error, or for any other determination of fact, made in good faith.

ARTICLE VI
COBRA CONTINUATION COVERAGE

The following provisions shall be applicable to any group health plan (as defined by Code Sections 4980B and 5000(b)(1)) subject to the COBRA Continuation Coverage requirements. The intent of this Article is to extend continuation rights required by the COBRA Continuation Coverage requirements. This Article operates in conjunction with the terms of the applicable Summary Plan Descriptions that include the Plan's COBRA Continuation Coverage provisions.

6.1 Continuation Coverage. Each Covered Person who is a qualified beneficiary and who would lose any coverage, which is required by law to be continued as COBRA Continuation Coverage, as a result of a qualifying event shall be entitled to elect, within the election period, continuation coverage under the Plan. For purposes of this Article VI, the terms qualified beneficiary, qualifying event, election period, and continuation coverage shall have the same meanings as those provided in the COBRA Continuation Coverage requirements.

6.2 Contribution Requirements. The Plan shall require payment of a contribution during the period of continuation coverage up to the maximum contribution amount permitted in the COBRA Continuation Coverage requirements. The contribution shall be periodically determined by the Committee and communicated to the qualified beneficiary.

6.3 Notice Requirements. The Plan and the Participating Company shall provide the required notice regarding COBRA Continuation Coverage as they may be required to provide under the COBRA Continuation Coverage requirements.

ARTICLE VII
AMENDMENT AND TERMINATION

7.1 Amendment of Plan. The Benefits Oversight Committee, through action of its own or through a duly designated member, reserves the right to amend the provisions of the Plan or any Benefit Program under the Plan at any time and from time to time, and retroactively if deemed necessary or appropriate, by written action. The exclusive authority to amend the Plan shall be vested in the Benefits Oversight Committee and no other Participating Company shall have any right to amend the Plan or right to prior notice. Any amendment to the Plan adopted by the Benefits Oversight Committee shall be documented in writing and binding upon every Participating Company without further action by the Participating Company.

The Benefits Oversight Committee or its designee or an authorized officer of the Company may amend the SPD at any time by publication of a revised SPD or Summary of Material Modification. The Benefits Oversight Committee or its designee or an authorized officer of the Company may amend Appendix D, any Contract or Insurance Contract at any time in accordance with the respective procedures as set forth therein.

7.2 Termination of Plan. The Company and any Participating Company shall have no obligation whatsoever to maintain the Plan or any Benefit Program under the Plan for any given length of time. The Benefits Oversight Committee reserves the right to terminate the Plan or any Benefit Program under the Plan in whole or in part at any time by written action. Upon termination or discontinuance of the Plan in its entirety, all elections and Compensation Reduction Agreements shall terminate, and payments for benefits shall be made only for Claims incurred on or before the date of the Plan's termination so long as the Claims are submitted within the applicable run-out period.

7.3 Participating Companies. Additional Affiliates may be included as Participating Companies for participation in the Plan by written action of the Benefits Oversight Committee. In addition, the Benefits Oversight Committee may terminate the designation of an Affiliate as a Participating Company to be effective on the date as the Benefits Oversight Committee specifies. A company's status as a Participating Company shall automatically cease as of the date it ceases to be an Affiliate unless otherwise agreed by the Company. Any Affiliate or former Affiliate that ceases to be a Participating Company shall be liable for the costs, liabilities and expenses as the Benefits Oversight Committee may establish.

7.4 Construction. Nothing in the Plan, or any other document describing, interpreting, or relating to the Plan shall be construed to provide vested, non-forfeitable, non-terminable, or non-changeable benefits or rights thereto. No communication, written or oral, may modify, supersede or void the terms of the Plan, unless the communication is a valid amendment to the Plan executed by the Benefits Oversight Committee pursuant to Section 7.1.

7.5 No Vested Right to Benefits. Notwithstanding anything in this Plan to the contrary, no Employee shall have any vested right to continued benefits under the Plan and any benefits or coverage may be altered or terminated at any time for periods after the amendment or termination of the Plan pursuant to Sections 7.1 and 7.2.

ARTICLE VIII
COMMITTEE

8.1 Named Fiduciaries. The Plan Administration Committee is the named fiduciary of the Plan (as that term is used in ERISA) and shall have the authority to control and manage the operation and administration of the Plan. A Claims Fiduciary reviewing the first appeal of denied claims shall be a named fiduciary with respect to reviewing the appeals and the Benefit Appeals Committee shall be a named fiduciary with respect to review of the subsequent appeals. The named fiduciary shall have only the powers and duties expressly allocated to it in the Plan and shall have no other powers and duties in respect of the Plan; provided, if a power or responsibility is not expressly allocated to a specific fiduciary, the power or responsibility shall be that of the Plan Administrator. No fiduciary shall have any liability for, or responsibility to inquire into, the acts and omissions of any other fiduciary in the exercise of powers or the discharge of responsibilities assigned to the other fiduciary under this Plan.

8.2 Plan Administration Committee.

(a) Purpose. The Plan Administration Committee shall serve as Plan Administrator and shall have exclusive authority and responsibility for those functions set forth in this Section 8.2 and in other provisions of this Plan relating to the Plan Administrator. The Plan Administrative Committee will consist of at least three members who will be appointed by and serve at the pleasure of the Chief Executive Officer of the Company or his designee. The Chief Executive Officer of the Company or his designee will have the right to remove any member of the Plan Committee at any time. A member may resign at any time by written resignation to the Chief Executive Officer of the Company or his designee. If a vacancy in the Plan Administration Committee should occur, a successor may be appointed by the Plan Administration Committee; provide that, if the Plan Administration Committee does not timely do so, the Chief Executive Officer of the Company or his designee may do so.

The Plan Administration Committee shall act by a majority of its members at the time in office, and such action may be taken by a vote at a meeting, in writing without a meeting, or by telephonic communications. A member of the Plan Administration Committee who is a Participant in the Plan shall not vote on any question relating specifically to such Participant. Any such action shall be voted or decided by a majority vote of the remaining members of the Plan Administration Committee. The Plan Administration Committee shall appoint a secretary who may, but need not, be a member of the Plan Administration Committee. The Plan Administration Committee may appoint from its members such subcommittees with such powers as the Plan Administration Committee may determine.

8.3 Powers and Responsibilities of the Plan Administration Committee.

(a) Plan Administrator. The Plan Administration Committee shall be responsible for the general administration of the Plan. As such, the Plan Administration Committee is the "Plan Administrator" of the Plan (as such term is used in ERISA). The Plan Administration Committee and its designated agents shall have the exclusive right

and discretion to interpret the terms and conditions of the Plan and to decide and interpret all matters arising with respect to the Plan's administration and operation (including factual issues). The Plan Administration Committee may execute any certificate, instrument or other written direction on behalf of the Plan and make any payment on behalf of the Plan. Any interpretations or decisions so made shall be conclusive and binding on all persons, subject to the Claims procedures described in each respective coverage document. The Plan Administration Committee, in the exercise of its authority, shall discharge its duties in accordance with ERISA and corresponding regulations, as amended from time to time.

(b) Delegation of Duties. For purposes of operation and administration of the Plan, the Plan Administration Committee may:

(i) appoint one or more other individuals, committees, or subcommittees whose members need not be members of the Plan Administration Committee or outside vendors, and determine their powers;

(ii) employ legal or other counsel and agents;

(iii) obtain clerical, accounting, claims administration and actuarial assistance;

(iv) authorize one or more Plan Administration Committee members or any agent to execute or to deliver any written instructions, requisitions, orders, notices or any other instruments, or to make payments on its behalf;

(v) allocate its fiduciary responsibilities among the members of the Plan Administration Committee; and

(vi) appoint administrators or other persons or outside vendors and to delegate these duties to each administrator or person or vendors as the Plan Administration Committee deems appropriate.

(c) In addition to all implied powers and responsibilities necessary to carry out the objectives of the Plan and to comply with the requirements of ERISA, the Plan Administration Committee shall have the following specific powers and responsibilities, all of which may be exercised in its sole discretion or delegated to others as set forth in subsection (b) above:

(i) To decide all questions relating to the eligibility of Employees to participate in the Benefits of the Plan;

(ii) To determine the benefits of the Plan, except for the Insured Benefit Programs, to which any Participant, Beneficiary or other person may be entitled;

(iii) To keep records of all acts and determinations of the Plan Administration Committee, and to keep all the records, books of accounts, data

and other documents as may be necessary for the proper administration of the Plan;

(iv) To prepare and distribute to all Plan Participants and Beneficiaries information concerning the Plan and their rights under the Plan, including, but not limited to, all information that is required to be distributed by ERISA or by any other applicable law;

(v) To file with the Secretary of Labor reports and additional documents as may be required by ERISA;

(vi) To file with the Secretary of the Treasury all reports and information required to be filed by the Internal Revenue Code, ERISA; and

(vii) To do all things necessary to operate and administer the Plan in accordance with its provisions and in compliance with applicable provisions of federal law.

(d) If any Plan Administration Committee member, or any officer, director or Employee of the Company or a Participating Company to whom authority has been delegated or redelegated hereunder shall also be a Participant in the Plan, the individual shall have no authority as the Plan Administration Committee member, officer, director or Employee with respect to any matter specially affecting his or her individual interest including the interest of an eligible Dependent hereunder (as distinguished from the interests of all Participants or a broad class of Participants), all the authority being reserved exclusively to the other Plan Administration Committee members, officers or Employees, as the case may be, to the exclusion of the Participant, and the Participant shall act only in his or her individual capacity in connection with the matter.

8.4 Compensation and Expenses of Plan Administration Committee. The members of the Plan Administration Committee shall receive no compensation for their duties hereunder, but the Plan Administration Committee shall be reimbursed for all reasonable and necessary expenses incurred in the performance of its duties, including counsel fees and expenses. The expenses of the Plan Administration Committee, including the compensation of administrators, actuaries, counsel, agents or others that the Plan Administration Committee may employ, shall be paid out of the assets of any trust established in connection with this Plan to the extent not paid by a Participating Company. The Plan Administration Committee or its designee may pay the expenses of administering the Plan or may reimburse the Company or other person performing administrative services with respect to the Plan if the Company or any other person directly pays the expenses at the request of the Plan Administration Committee.

8.5 Indemnification of Plan Administration Committee. A Participating Company shall indemnify the members of the Plan Administration Committee, Benefits Oversight Committee, and officers or Employees of the Company or a Participating Company against any personal liability or cost not provided for in the preceding sentence which they may incur as a result of any act or omission in relation to the Plan or its Participants with the exception of acts

constituting gross negligence or willful misconduct. A Participating Company may purchase fiduciary liability insurance to insure its obligation under this Section 8.5.

ARTICLE IX
HIPAA PRIVACY AND SECURITY PROVISIONS

This Article IX applies to any Health Benefit Options and does not apply to non-health benefits or benefits that provide or pay for the cost of excepted benefits that are listed in 42 U.S.C. §300gg 91(c)(1).

9.1 Use and Disclosure of Protected Health Information (PHI).

(a) General. The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA, including but not limited to health care treatment, payment for health care, health care operations and as required by law. The Privacy Notice will list the specific uses and disclosure of PHI that will be made by the Plan.

(b) Disclosure to the Company. The Plan will disclose PHI to the Company, or where applicable, another Participating Company as only upon receipt of written certification from the Company that the Plan document has been amended to incorporate the provisions in this Article IX and the Company agrees to implement the provisions in Section 9.2.

9.2 Conditions Imposed on the Company. Notwithstanding any provision of the Plan to the contrary, all Participating Companies agree:

(a) Not to use or disclose PHI other than as permitted or required by this Article IX or as required by law;

(b) To ensure that any agents, including a subcontractor, to whom the Company provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to PHI received or created on behalf of the Plan and ensure that these individuals agree to implement reasonable and appropriate security measures to protect electronic PHI;

(c) Not use or disclose an individual's PHI for employment-related purposes (including hiring, firing, promotion, assignment or scheduling) unless authorized by the Individual, except the Company may use enrollment, disenrollment and eligibility information as permitted by 45 C.F.R. Parts 160-164 to perform enrollment and disenrollment functions;

(d) Not to use or disclose an Individual's PHI in connection with any other non-health benefit program of the Company unless authorized by the Individual;

(e) To report to the Plan any use or disclosure of PHI that is inconsistent with this Article IX if it becomes aware of an inconsistent use or disclosure or any Security Incident;

(f) To provide Individuals with access to PHI in accordance with 45 C.F.R. § 164.524;

(g) To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;

(h) To make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

(i) To make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;

(j) If feasible, to return or destroy all PHI received from the Plan that the Company maintains in any form, and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible;

(k) To ensure adequate separation supported by reasonable and appropriate security measures is implemented between the Plan and Company as required by 45 C.F.R. § 164.504(f)(2)(iii); and

(l) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that the Company creates, receives, maintains or transmits on behalf of the Plan.

9.3 Designated Employees Who May Receive PHI. In accordance with the privacy and security provisions of HIPAA, only certain Employees who perform Plan administrative functions may be given access to PHI. Those Employees who have access to PHI from the Plan are listed in Appendix F.

9.4 Restrictions on Employees with Access to PHI. The Employees who have access to PHI listed in Appendix F may only use and disclose PHI for Plan Administration functions that the Company performs for the Plan, as indicated in the Privacy Notice, including but not limited to, quality assurance, claims processing, auditing, monitoring, and management of the Benefit Programs.

9.5 Policies and Procedures. The Company shall implement Policies and Procedures with the operating rules to implement the provisions in this Article.

9.6 Organized Health Care Arrangement. The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other Benefit Program under a covered health plan (under 45 C.F.R. § 160.103) provided by the Company.

9.7 Hybrid Entity Designation. The Plan Administrator intends the Plan to be a Hybrid Entity in accordance with 45 C.F.R. § 164.504(b) and only those Benefit Programs that are a covered health plan under 45 C.F.R. § 160.103 (if set forth as a separate plan) will be the health care components of the Plan. Any Benefit Program offered by the Plan that would not be

a covered health plan under 45 C.F.R. §160.103 if provided through a separate plan is a non-health care component of the Hybrid Entity and is not subject to the HIPAA privacy provisions.

9.8 Privacy Official and Security Official. The Plan shall designate a Privacy Official and a Security Official, each of whom will be responsible for the Plan's compliance with the privacy and security provisions of HIPAA. The Privacy and Security Officials may be the same individual. The Privacy Official and Security Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as they deem necessary or advisable. In addition, and notwithstanding any provision of this Plan to the contrary, each official shall have the authority to and be responsible for:

(a) Accepting and verifying the accuracy and completeness of any certification provided by the Company under this Article IX;

(b) Transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to Company;

(c) Establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Plan with the Privacy requirements of HIPAA;

(d) Establishing and overseeing proper training of the Company personnel who will have access to PHI; and

(e) Any other duty or responsibility that the Privacy or Security Official, in his or her sole capacity, deems necessary or appropriate to comply with the privacy and security provisions of HIPAA and the purposes of this Article IX.

9.9 Noncompliance. The Company shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Article IX.

9.10 Services Performed for the Company. Notwithstanding any other provision of this Plan to the contrary, all services performed by a business associate for the Plan in accordance with the applicable service agreement shall be deemed to be performed on behalf of the Plan and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. parts 160 through 164, except services that relate to eligibility and enrollment in the Plan. If a business associate of the Plan performs any services that relate to eligibility and enrollment to the Plan, these services shall be deemed to be performed on behalf of the Company in its capacity as Plan Sponsor and not on behalf of the Plan.

9.11 Eligibility and Enrollment. Determining the Employee's eligibility for the Plan or any Benefit Program offered under the Plan or enrolling Employees in the Plan is an employer function performed by the Participating Companies. Employee and Dependent eligibility and enrollment information is the Participating Companies information and not the Plan's information while it is held and transmitted by the Participating Companies.

9.12 Interpretation and Limited Applicability. This Article IX serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner to effectuate this purpose. Neither this Article IX nor the duties, powers, responsibilities, and obligations listed in this Plan shall be taken into account in determining the amount or nature of the Benefits provided to any person covered under this Plan, nor shall they inure to the benefit of any third parties. To the extent that any of the provisions of this Article IX are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

ARTICLE X
MISCELLANEOUS PROVISIONS

10.1 Plan is Not an Employment Contract. This Plan is not a contract of employment, and neither the Plan nor the payment of any benefits under the Benefit Programs will be construed as giving to any person any legal or equitable right to employment by any Participating Company. Nothing in this Plan shall be construed to interfere with the right of the Company or any Participating Company to discharge, with or without cause, any Employee at any time.

10.2 Assignment. If applicable, a Covered Person may authorize the Plan to directly pay the service provider or hospital that provided the Covered Person's covered care and treatment. Except as provided in the foregoing sentence, and subject to Section 10.6 of this Plan relating to Qualified Medical Child Support Orders, a Covered Person may not assign or alienate any payment for any Benefit Program that he or she is entitled to receive from the Plan. In addition, except as may be prescribed by law, no benefits shall be subject to attachment or garnishment of or for a Covered Person's debts or contracts, except for recovery of overpayments made on a Covered Person's behalf by this Plan.

10.3 Fraud. No payments for benefits under this Plan will be paid if the Covered Person or the provider of service attempts to perpetrate a fraud upon the Plan relating to the Claim. For the self-funded Benefit Programs, the Plan Administrator shall have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made, and its decision shall be final, conclusive and binding upon all persons. The Plan shall have the right to fully recover any amounts, with interest, improperly paid by the Plan by reason of fraud, attempted fraud or misrepresentation of fact by a Covered Person or service provider and to pursue all other legal or equitable remedies.

10.4 Funding Status of Plan. The Company may fund any or all of the Benefit Programs provided under this Plan on a self-funded basis, through a Code Section 501(c)(9) trust, or through insurance policies or any combination thereof. Nothing in this Plan will be construed to require any Participating Company or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Covered Person. No Covered Person or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Participating Company from which any payment under the Plan may be made.

10.5 Construction. This Plan shall be construed, administered and enforced according to the laws of the State of Tennessee, except (i) to the extent preempted by federal law; or (ii) for those matters specifically governed by the corporation laws of the state of the Company's corporation, if different. The headings and subheadings are for convenient reference only and have no substantive effect whatsoever. All pronouns and all variations shall be deemed to refer to the masculine, feminine, singular or plural, as the identity of the person, persons or entity may require.

10.6 Qualified Medical Child Support Orders (QMCSO). The Plan Administrator shall comply with any QMCSO (as defined in ERISA Section 609(a)(2)(A)) and the Plan Administration Committee shall establish and follow procedures for (i) notifying Employees and

alternate recipients (as defined in ERISA Section 609(a)(2)(C)) who have or may have an interest in the Benefit Programs that are the subject of a medical child support order, (ii) determining whether the medical child support orders are QMCSOs under ERISA, and (iii) administering the provision of benefits under the QMCSO.

10.7 Conclusiveness of Records. The records of the Participating Companies regarding the age, employment history, compensation, absences, illnesses and all other relevant matters shall be conclusive for purposes of the administration of, and the resolution of Claims arising under, the Plan.

10.8 Right to Require Information and Reliance Thereon. Each Participating Company and the Plan Administrator shall have the right to require any Covered Person to provide it and its agents with the information, in writing or in any other form as it may deem helpful to the administration of the Plan, and may rely on that information in carrying out its duties under this Plan. Any payment to a Covered Person in accordance with the provisions of the Plan in good faith reliance upon any written information provided by the Covered Person shall be in full satisfaction of all Claims by the Covered Person.

10.9 Income and Employment Taxes. In the event a Participant is to receive a cash benefit payment under the Plan, the Participant is responsible for the expense of any income tax required to be withheld from and any employment tax imposed on the Participant with respect to the cash payment. In the Plan Administrator's discretion, the amount of any applicable tax may be deducted from the cash payment, or paid by the Participant in any other manner permitted by the Plan Administrator.

10.10 Disaggregation for Certain Discrimination Testing. To the extent that the Plan provides different Benefit Programs (or levels of Benefit Programs) or imposes different contribution rates to different classifications of Employees (*e.g.*, part-time, full-time Employees or geographic locations) or as otherwise described in the enrollment materials and various Summary Plan Descriptions, then solely for discrimination testing purposes under Code Sections 79, 125, 129, and 105(h) and under the authority of Treasury Regulation Section 1.105-11(c)(4), the Plan may be designated as separate Plans. The Company designates separate plans for the following groups of Employees: full-time, part-time, and Employees at each separate facility.

10.11 Facility of Payment. Unless otherwise provided in the Summary Plan Descriptions, or Insurance Contracts, if a Participant, eligible Dependent or beneficiary is entitled to receive any direct payment under the Plan and the individual has a legal disability, including minority, the Plan shall pay the payment to the following, provided that the Plan Administrator received written notification of the existence of these conditions:

(a) to the duly appointed guardian, conservator or other legal representative of the Participant, eligible Dependent or beneficiary; or

(b) to a person or institution entrusted with the care or maintenance of the incompetent or disabled Participant, Enrolled Dependent or beneficiary, provided the person or institution has satisfied the Plan Administrator that the payment will be used for the best interest of the Participant, Enrolled Dependent or beneficiary.

Any payment made in accordance with the provisions of this Section is a complete discharge of any liability or obligation of the Company, Participating Company, and the Plan. In the event of the death of the Participant, eligible Dependent or beneficiary, claims for expenses incurred before the Participant's death may be presented by the personal representative of the Participant's, eligible Dependent's or beneficiary's estate, and benefit payments not completed at death shall be made to the personal representative.

10.12 Mental or Physical Incompetency. Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that the person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

10.13 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because he cannot ascertain the identity or whereabouts of the Participants or other person after reasonable efforts have been made to identify or locate the person, the payment and all subsequent payments otherwise due to the Participant or other person shall be forfeited after a reasonable time after the date any payment first became due.

10.14 Requirement for Proper Forms. All communications in connection with the Plan made by a Participant shall become effective only when made on any forms or media as may be required and furnished by, and filed with, the Plan Administrator.

IN WITNESS WHEREOF, the Company has caused this Plan to be signed by its duly authorized officer on the 29th day of December, 2009.

HCA INC.

By: _____

Title: Vice President, Human Resources
Compensation & Benefits

APPENDIX A
DAY CARE FLEXIBLE SPENDING ACCOUNT (DAY CARE FSA) BENEFIT PROGRAM

PART I
PURPOSE

The Day Care FSA Benefit Program has been established by the Company to allow Participants to pay for Eligible Dependent Care Expenses on a pre-tax basis. The Day Care FSA Benefit Program is intended to allow Participants who elect to make contributions to a Dependent Care Account to submit Eligible Dependent Care Expenses to the Plan Administrator (or its designated claims administration representative) for reimbursement from the Participant's Dependent Care Account.

The benefits provided under the Day Care FSA Benefit Program are intended to be eligible for exclusion from the Participant's income for Federal income tax purposes under Code Section 129. The Day Care FSA Benefit Program is a benefit program under, and incorporated by reference into, the Plan.

PART II
DEFINITIONS

Unless otherwise specified, terms that are capitalized in this Appendix A have the same meaning as the defined terms in the Plan. The definitions of terms defined in this Appendix A, but not defined in Article II of the Plan, shall be applicable only to this Appendix A.

2.01 Dependent Care Account means the account described in Part V of this Appendix A.

2.02 Dependent Care Expenses means reasonable expenses incurred by the Participant for the care of a Qualifying Individual to enable the Participant or his or her Spouse to remain gainfully employed or to enable the Spouse to remain a Student at an Educational Institution, subject to any limitations under this Plan. The Plan Administrator (or its designated claims administration representative) shall determine in its sole discretion whether any expense is reasonable. To be eligible for reimbursement as an Eligible Dependent Care Expense, an expense must be related to:

(a) the cost of sending a child or other Eligible Dependent of the Participant to an Eligible Day Care Center,

(b) the cost of custodial care performed in the home of the Participant for an Eligible Dependent, or

(c) the cost of custodial care performed outside the home of the Participant for:

(i) the care of an Eligible Dependent of the Participant age 12 or under who lives with the Participant, or

(ii) the care of any other Eligible Dependent who spends at least eight hours a day in the Participant's home.

An expense shall be an eligible Dependent Care Expense only if it is payable to a person who is not:

(A) a dependent of the Participant or the Participant's Spouse (within the meaning of Code Section 152(a)),

(B) the Participant's Spouse,

(C) a child of the Participant under the age of 19 (or age 24 if a Student) as of the close of the Plan Year in which the custodial care services with respect to the Eligible Dependent are rendered, or

(D) a parent of an Eligible Dependent.

2.03 Earned Income means all income derived from salaries, wages, tips, self-employment, overtime, bonuses and other employee compensation (such as disability or wage continuation benefits) but does not include any amounts: (i) received under this Day Care FSA Benefit Program or any other dependent care assistance program under Code Section 129, (ii) as a pension or annuity, or (iii) as unemployment or worker's compensation. In the case of a Spouse who is a full-time Student at an Educational Institution or is physically or mentally incapable of caring for himself or herself, the Spouse shall be deemed to have earned income of not less than $250 per month if the Participant has one Eligible Dependent and $500 per month if the Participant has two or more Eligible Dependents.

2.04 Educational Institution means any educational institution that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

2.05 Eligible Day Care Center means a day care center that provides full or part-time care for more than six individuals (other than individuals who reside at the day care center) on a regular basis during the calendar year, and which:

(a) complies with all applicable laws and regulations of the state and town, city or village in which it is located, and

(b) receives a fee, payment or grant for services for any of the individuals to whom it provides services (regardless of whether the facility is operated for profit).

2.06 Grace Period means the time period immediately following the end of a Plan Year during which a Participant may receive reimbursement for eligible Dependent Care Expenses from the unused balance remaining in the Participant's Dependent Care Account. The Grace Period for the Plan ends on the March 15th following the end of the plan Year.

2.07 Qualifying Individual means:

(a) a Qualifying Child of a Participant (as defined in Code Section 152(a)(1)) who is under the age of 13, except a child of divorced parents will be considered an Eligible Dependent of the parent with whom the child resides with for the longest portion of the year without regard to who is entitled to the exemption;

(b) a Dependent as defined in Code Section 152 (determined without regard to subsections 152(b)(1), 152(b)(2) and 152(d)(1)(B)) of a Participant who is mentally or physically incapable of caring for himself or herself and who has the same principal place of above as the Participant for more than half the year; or

(c) the Spouse of a Participant who is mentally or physically incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than half the year.

2.08 Run-Out Period means the period of time immediately following the Plan Year in which a Participant may submit Claims for reimbursement of Eligible Dependent Care Expenses incurred during a Plan Year or its related Grace Period. The Run-Out Period under the Plan ends on the March 31st following the end of the Plan Year. Any amounts that remain in a Participant's Dependent Care Account on the date following the end of the Run-Out Period will be forfeited in accordance with Section 5.04 of this Appendix A.

PART III
PARTICIPATION

3.01 Commencement of Participation. Each Eligible Employee may participate in the Day Care FSA Benefit Program in accordance with the Summary Plan Descriptions. An Eligible Employee who elects, by completing a Compensation Reduction Agreement, to contribute to a Dependent Care Account during the Annual Enrollment Period will become a Participant on the first day of the following Plan Year. An Eligible Employee who elects, by completing a Compensation Reduction Agreement, to contribute to a Dependent Care Account that is effective other than at the beginning of a Plan Year shall become a Participant the later of: (i) the date of the event; (ii) the date that the election and Compensation Reduction Agreement is submitted to the Plan Administrator; or (iii) if the Compensation Reduction Agreement is submitted in December, participation will begin the following January.

3.02 Cessation of Participation. A Participant will cease to be a Participant in the Day Care FSA Benefit Program as of the earlier of:

(a) the date on which the Day Care FSA Benefit Program terminates;

(b) the end of the Plan Year (as extended by the Grace Period, as applicable) unless the Participant makes another election to receive benefits under this Day Care FSA Benefit Program for the next Plan Year;

(c) the date on which the Participant's participation is cancelled for failure to make timely payment of any Benefit Contributions;

(d) the date on which the Participant is no longer an Eligible Employee;

(e) two weeks after the date on which the Participant takes a leave of absence; or

(f) the date of termination provided in the Plan.

In the event that a Participant ceases to be a Participant in this Day Care FSA Benefit Program for any reason during a Plan Year, the Participant's Compensation Reduction Agreement relating to this Day Care FSA Benefit Program shall terminate.

PART IV
ELECTIONS

4.01 Compensation Reduction Agreement. A Participant may elect to contribute to a Dependent Care Account under this Day Care FSA Benefit Program and to receive reimbursements of Eligible Dependent Care Expenses not in excess of his or her coverage amount by filing an election and Compensation Reduction Agreement in accordance with the procedures established in the Summary Plan Descriptions.

4.02 Maximum Contribution Amount. The maximum amount a Participant may elect to contribute to his or her Dependent Care Account in a Plan Year is the lesser of the following amounts:

(a) $5,000 if the Participant is single or a married individual filing a joint federal income tax return (prorated for any Participant who enrolls mid-year);

(b) $2,500 if the Participant is a married individual filing a separate federal income tax return (prorated for any Participant who enrolls mid-year);

(c) the Earned Income of the Participant for the Plan Year; or

(d) the Earned Income of the Spouse of the Participant for the Plan Year.

Notwithstanding subparagraphs (a) through (d), the Plan Administrator (or its designated claims administration representative) may change at any time the amount that may be contributed for a Plan Year with respect to any Participant in order to prevent the amount of the contributions from exceeding the applicable limits, or for purposes of satisfying any applicable nondiscrimination test required by the Code for any Participant who is a highly compensated individual (as defined by the Code).

4.03 Duration of Elections. Except as provided in Section 4.7 of the Plan and the Summary Plan Descriptions, any Compensation Reduction Agreement for the Day Care FSA Benefit Program shall remain in effect until the end of the Plan Year for which it was made. No change or revocation of a Compensation Reduction Agreement shall be permitted except as provided in Section 4.7 of the Plan and the Summary Plan Descriptions. If the Participant is permitted to change his or her election and Compensation Reduction Agreement during the Plan Year as provided in Section 4.7 of the Plan and the Summary Plan Descriptions, then under no

circumstances may the recalculated amount contributed be less than what has previously been contributed.

4.04 Leave of Absence. If a Participant takes a leave of absence, participation in the Day Care FSA Benefit Program will cease on the date that is two weeks after the date the leave of absence began. Upon timely return, the Participant will be entitled to make a new election to participate in the Day Care FSA Benefit Program. Dependent Care Expenses incurred during the period that the Participant's coverage was not in effect are not eligible for reimbursement under the Day Care FSA Benefit Program.

PART V
DEPENDENT CARE ACCOUNTS

5.01 Establishment of Accounts. The Company will establish and maintain a separate non-interest bearing Dependent Care Account for each Plan Year for each Participant who elects to participate in the Day Care FSA Benefit Program. The Dependent Care Account will be maintained solely as a bookkeeping account used to reflect the amount allocated as contributions to and benefits received under the Day Care FSA Benefit Program for each Participant.

5.02 Crediting of Accounts. A Participant's Dependent Care Account will be credited each payroll period with an amount equal to the reduction in compensation, if any, to be made in accordance with the Participant's election under the Plan. Except as otherwise required by law, all amounts credited to the Participant's Dependent Care Account shall be the property of the Company until paid out under Part VI of this Appendix A.

5.03 Debiting of Accounts. A Participant's Dependent Care Account shall be debited from time to time in the amount of any payment under Part VI of this Appendix A to or for the benefit of the Participant for Eligible Dependent Care Expenses incurred during the Plan Year. Amounts debited to each Dependent Care Account shall be treated as payments of the earliest amount credited to the Account and not yet treated as paid under this sentence, under a "first-in/first-out" approach.

5.04 Forfeiture of Accounts. The amount credited to a Participant's Dependent Care Account for any Plan Year shall be used only to reimburse the Participant for Eligible Dependent Care Expenses incurred during the Plan Year or its related Grace Period and while the Participant is covered under the Day Care FSA Benefit Program, provided the Participant applies for reimbursement on or before the Run-Out Period. If any balance remains in the Participant's Dependent Care Account after the Run-Out Period, the balance shall be forfeited by the Participant. The Company may, in its discretion, retain the forfeitures in its general assets, allocate forfeited account balances among Participants, or use the forfeited amounts to offset Plan administrative costs.

PART VI
PAYMENT OF ELIGIBLE DEPENDENT CARE EXPENSES

6.01 Claims for Reimbursement. A Participant who incurs an Eligible Dependent Care Expense may apply to the Plan Administrator (or its designated claims administration

representative) for reimbursement of the Eligible Dependent Care Expense. The application shall be in the form as the Plan Administrator (or its designated claims administration representative) may prescribe. The application shall be accompanied by a written statement or invoice from an independent third party stating or indicating that the expense has been incurred and the amount of the expense. The Plan Administrator (or its designated claims administration representative) may also require as part of the application other information or documentation as it may deem necessary or desirable to ascertain the eligibility of a Participant's Claim for reimbursement (*e.g.*, bills, receipts, canceled checks). Claims for reimbursement of Eligible Dependent Care Expenses must be submitted no later than the last day of the Run-Out Period or 90 days after the Participant ceases to participate in the Day Care FSA Benefit Program, if earlier.

6.02 Reimbursement or Payment of Expenses. A Participant shall be reimbursed for Eligible Dependent Care Expenses, in the time and manner established by the Plan Administrator (or its designated claims administration representative) may prescribe, no less frequently than monthly. A Participant may only be reimbursed for Eligible Dependent Care Expenses incurred during the Plan Year or its related Grace Period and while the Participant was covered under the Day Care FSA Benefit Program. The Plan Administrator (or its designated claims administration representative) may, at its option, or in accordance with the Participant's written direction, pay any Eligible Dependent Care Expenses directly to the person providing services related to these expenses in lieu of reimbursing the Participant. No reimbursement or payment of expenses shall at anytime exceed the balance of the Participant's Dependent Care Account at the time of the reimbursement or payment.

6.03 Claims Procedure. The process by which a Claim for Benefits shall be handled by the Plan Administrator (or its designated claims administration representative) and the process by which a Participant may appeal the denial of a Claim for Benefits are stated in the Summary Plan Descriptions and incorporated by reference.

6.04 Report(s) to Participants. The Plan Administrator shall provide to each Participant (or former Participant) who has received reimbursement of Eligible Dependent Care Expenses under this Day Care FSA Benefit Program during the Plan Year a written statement showing the amount of the assistance paid during the year with respect to the Participant (or former Participant). These reports must be provided at least annually, but may be provided more frequently.

6.05 Limitation on Reimbursements or Payments with Respect to Certain Participants. Notwithstanding any other provisions of this Day Care FSA Benefit Program, the Plan Administrator may limit the amounts reimbursed or paid with respect to any Participant who is a highly compensated individual (as defined by the Code) to the extent the Plan Administrator deems the limitation to be necessary to assure compliance with any nondiscrimination provision of the Code. The limitation may be imposed whether or not it results in forfeiture under Section 5.04 of this Appendix A.

PART VII
MISCELLANEOUS

7.01 Funding Status of Day Care FSA Benefit Program. Except as may otherwise be required by law or under the terms of the Plan:

(a) Any amount by which a Participant's taxable compensation is reduced by reason of an election made under this Day Care FSA Benefit Program will remain part of the general assets of the Company;

(b) The benefits provided under the Day Care FSA Benefit Program will be paid solely from the general assets of the Company;

(c) Nothing in this Plan will be construed to require the Company or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant; and

(d) No Participant or other person shall have any Claim against, right to, or security or other interest in, any fund, account or asset of the Company from which any payment under the Day Care FSA Benefit Program may be made.

7.02 Assignment. The Participant may, if permitted by the Plan Administrator, authorize the Day Care FSA Benefit Program to pay a Participant's or Dependent's reimbursement directly to the service provider that provided the Dependent with covered Dependent Care Expenses. A Participant, however, may not assign, alienate, anticipate or commute any payment with respect to any reimbursements or Eligible Dependent Care Expenses that a Participant is entitled to receive from the Day Care FSA Benefit Program and, further, except as may be required by law, no benefits shall be subject to any attachments or garnishments of or for a Participant's or Dependent's debts or contracts, except for recovery of overpayments made by this Day Care FSA Benefit Program.

7.03 No Guarantee of Tax Consequence. Neither the Plan Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Day Care FSA Benefit Program will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Day Care FSA Benefit Program is excludable from the Participant's gross income for Federal and state income tax purposes, and to notify the Company if the Participant has reason to believe that any payment is not so excludable.

7.04 Indemnification of Company by Participants. If any Participant receives one or more payments or reimbursements under this Plan that are not for Eligible Dependent Care Expenses, the Participant shall indemnify and reimburse the Company for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from the payments or reimbursements.

7.05 Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Dependent Care Expenses that have been substantiated by the Participant during the Plan Year as required in this Plan document or reimbursements have been made in error (*e.g.*, reimbursements were made for expenses incurred for the care of an individual who was not a Qualifying Individual), the Plan Administrator shall recoup the excess reimbursements in one or more of the following ways:

(a) The Plan Administrator shall give the Participant prompt written notice of any excess amount, and the Participant shall repay the amount of the excess to the Company within 60 days of receipt of the notification.

(b) The Plan Administrator may offset the excess reimbursement against any other Eligible Dependent Care Expenses submitted for reimbursement.

(c) The Plan Administrator may withhold the amounts from the Participant's pay (to the extent permitted under applicable law).

If the Plan Administrator is unable to recoup the excess reimbursement as stated in (a)-(c), the Plan Administrator will notify the Company that the funds could not be recouped and the Company will treat the excess reimbursement as it would any other bad business debt.

7.06 Program Not Part of an ERISA Plan. The Day Care FSA Benefit Program is not intended to be subject to ERISA, even though included as part of a written Plan that may be subject to ERISA.

APPENDIX B
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HEALTH CARE FSA) BENEFIT PROGRAM

PART I
PURPOSE

The Health Care FSA Benefit Program has been established by the Company to allow Participants to pay for Eligible Health Care Expenses on a pre-tax basis. The Health Care FSA Benefit Program is intended to allow Participants who elect to make contributions to a Health Care Account to submit Eligible Health Care Expenses to the Plan Administrator (or its designated claims administration representative) for reimbursement from the Participant's Health Care Account.

The Health Care FSA Benefit Program is intended to qualify as an accident and health plan within the meaning of Code Section 105(e). It is further intended that the benefits provided under the Health Care FSA Benefit Program be eligible for exclusion from the Participant's income for Federal income tax purposes under Code Section 105(b). The Health Care FSA Benefit Program is a benefit program of, and incorporated by reference into, the Plan.

PART II
DEFINITIONS

Unless otherwise specified, terms that are capitalized in this Appendix B have the same meaning as the defined terms in the Plan. The definitions of terms defined in this Appendix B, but not defined in Article II of the Plan, shall be applicable only with respect to this Appendix B.

2.01 Coverage Amount means the amount of Health Care Account coverage elected by the Participant for the Plan Year under Part IV of this Appendix B.

2.02 Dependent means, for the purpose of this Appendix B only:

(a) a person who is defined as a dependent under Code Section 152 (without regard to subsections (b)(1), (b)(2), and (d)(1)(B)); and

(b) any child of the Participant to whom Code Section 152(e) (regarding divorced or separated parents) applies.

No Dependent of a Participant, because of his or her status as a Dependent, shall be considered a beneficiary under this Health Care FSA Benefit Program. All reimbursements made from a Participant's Health Care Account shall be made in accordance with the expenses submitted for reimbursement from time to time by the Participant, and no Dependent shall have any right on his or her own behalf to Claim reimbursements under this Health Care FSA Benefit Program or to require the Participant to submit reimbursements on a Dependent's behalf.

2.03 Determination Date means the date a Participant submits a request to the Plan Administrator for a Qualified Reservist Distribution.

2.04 Eligible Health Care Expense means, for purposes of the Health Care Account, an expense incurred by a Participant for medical care as defined in Code Section 213(d) (including without limitation amounts paid for hospital bills, doctor and dental bills, and prescribed and certain over-the-counter drugs as described in the Summary Plan Descriptions and in Internal Revenue Service Publication 502), provided for the Participant or the Participant's legal Spouse or Dependent, but only to the extent that the Participant or other person receiving medical care is not reimbursed (or entitled to reimbursement) for the expense through insurance or otherwise (other than under this Health Care FSA Benefit Program). The Plan Administrator may establish procedures regarding the eligibility of various expenses for reimbursement as Eligible Health Care Expenses, and may limit reimbursements to expenses described in the procedures. An Eligible Health Care Expense does not include:

(a) any premium or contribution paid for health insurance or long term care insurance premiums;

(b) an expense incurred for the purpose of cosmetic surgery as defined by Code Section 213(d)(9); or

(c) any other expense excluded under Code Section 125 and the terms of the Plan or the Summary Plan Descriptions.

Eligible Health Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered, not when the Participant or Dependent is billed or charged for the service.

2.05 Grace Period means the time period immediately following the end of a Plan Year during which a Participant may receive reimbursements for Eligible Health Care Expenses from the unused balance remaining in the Participant's Health Care Account. The Grace Period for the Plan ends on the March 15th following the end of the Plan Year.

2.06 Health Care Account means the health care reimbursement account described in Part V of this Appendix B.

2.07 Qualified Reservist Distribution means a distribution made:

(a) to a Participant while the Participant was, by reason of being a member of a reserve component (as defined in section 101 of title 37, United States Code), ordered or called to active duty for a period of 180 days or more, or for an indefinite period;

(b) in the amount of the Participant's Benefit Contributions and any Company Contributions made to the Health Care Account during the Plan Year that have not been applied to provide reimbursements of Eligible Health Care Expenses determined as of the Determination Date in accordance with the Plan Administrator's policies and procedures; and

(c) no earlier than the date of the order or call and no later than the last date that reimbursements could otherwise be made under the Health Care FSA Benefit Program for the Plan Year which includes the date of the order or call described in (a).

2.08 Required Premium means an amount equal to the periodic contribution that the Participant is required to make to the Health Care Account pursuant to his or her election and Compensation Reduction Agreement or on an after-tax basis pursuant to an election for COBRA continuation coverage.

2.09 Run-Out Period means the period of time immediately following the Plan Year during which a participant may submit Claims for reimbursement of Eligible Health Care Expenses incurred during a Plan Year or applicable Grace Period. The Run-Out Period under the Plan ends on the March 31st following the end of the Plan Year. Any amounts that remain in a Participant's Health Care Account on the date following the end of the Run-Out Period will be forfeited in accordance with Section 5.04 of this Appendix B.

2.10 Terminated Participant means a Participant who separates from the service of a Participating Company (including by reason of layoff), begins an unpaid Leave or Absence, or otherwise ceases to be a Participant in accordance with Section 3.02 of this Appendix B.

PART III
PARTICIPATION

3.01 Commencement of Participation. Each Eligible Employee may participate in the Health Care FSA Benefit Program in accordance with the Summary Plan Descriptions. An Eligible Employee who elects, by completing a Compensation Reduction Agreement, to contribute to a Health Care Account during the Annual Enrollment Period will become a Participant on the first day of the following Plan Year. An Eligible Employee who elects, by completing a Compensation Reduction Agreement, to contribute to a Health Care Account that is effective other than at the beginning of a Plan Year shall become a Participant on the later of (i) the date of the event; (ii) the date that the election and Compensation Reduction Agreement is submitted to the Plan Administrator; or (iii) if the Compensation Reduction Agreement is submitted in December, participation will being the following January.

3.02 Cessation of Participation. A Participant will cease to be a Participant in the Health Care FSA Benefit Program as of the earlier of:

(a) the date on which the Health Care FSA Benefit Program terminates;

(b) the end of the Plan Year, unless the Participant makes another election to receive benefits under this Health Care FSA Benefit Program for the next Plan Year;

(c) the date on which the Participant's coverage is cancelled for failure to make timely payment of any Required Premium (which the payment is made by means of Compensation reduction or otherwise);

(d) the date on which the Participant is no longer an Eligible Employee unless the Participant timely elects COBRA continuation coverage; and

(e) the date of termination as provided in the Plan.

In the event that a Participant ceases to be a Participant in this Health Care FSA Benefit Program for any reason during a Plan Year, the Participant's Compensation Reduction Agreement relating

to this Program Benefit shall terminate. A Terminated Participant's coverage under this Health Care FSA Benefit Program shall cease on the date set forth in subparagraph (a) through (e) above. Unless the Terminated Participant is eligible and elects to make Required Premium payments on an after-tax basis pursuant to the COBRA provisions in Article VI, he or she shall not be entitled to reimbursement of Claims for Eligible Health Care Expenses that are incurred after the date his or her participation in the Health Care FSA Benefit Program ceases. A Terminated Participant shall be entitled to reimbursement for Claims incurred before the date his or her participation in the Health Care FSA Benefit Program ceased (up to the balance of his or her Health Care Account, including Claims incurred and submitted but not yet reimbursed) provided the Participant applies for the reimbursement no later than 90 days after the Participant ceases to participate in the Health Care FSA Benefit Program.

PART IV
ELECTIONS

4.01 Compensation Reduction Agreement. A Participant may elect to contribute to a Health Care Account under this Health Care FSA Benefit Program and to receive reimbursements of Eligible Health Care Expenses not in excess of his or her Coverage Amount by filing an election and Compensation Reduction Agreement in accordance with the procedures established in the Summary Plan Descriptions.

4.02 Maximum Contribution Amount. A Participant may elect to receive payments or reimbursements of Eligible Health Care Expenses incurred in any Plan Year while the Participant is covered under the Health Care FSA Benefit Program from the minimum amount as may be described in the Summary Plan Descriptions up to any dollar amount specified by the Participant, but not exceeding $5,000, or another amount as may be described in the Summary Plan Descriptions or enrollment materials. The Company, in its sole discretion, may change the maximum amount that may be contributed for a Plan Year for any highly compensated individual (as defined by the Code) to satisfy any applicable nondiscrimination tests.

4.03 Duration of Elections. Except as provided in Section 4.7 of the Plan and the Summary Plan Descriptions, any Compensation Reduction Agreement for the Health Care FSA Benefit Program shall remain in effect until the end of the Plan Year for which it was made. No change or revocation of a Compensation Reduction Agreement shall be permitted except as provided in Section 4.7 of the Plan and the Summary Plan Descriptions. If the Participant is permitted to change his or her election and Compensation Reduction Agreement during the Plan Year under Section 4.7 of the Plan and the Summary Plan Descriptions, the Required Premium shall equal the Coverage Amount elected by the Participant for the remainder of the Plan Year divided by the remaining months in the Plan Year or another amount as determined by the Plan Administrator that will cause the Participant's elected Coverage Amount to be contributed to his or her Health Care Account on a *pro rata* basis between the effective date of the new election and the end of the Plan Year. Under no circumstances may the recalculated amount contributed be less than what has previously been contributed.

4.04 Leave of Absence. If coverage under the Health Care FSA Benefit Program ceases during any FMLA leave of absence, a Participant will be entitled to make a new election to participate in the Health Care FSA Benefit Program upon return. Expenses incurred during

the period that the Participant's coverage was not in effect are not eligible for reimbursement under the Health Care FSA Benefit Program. The Company may establish rules regarding the payment of contributions as it may consider necessary or desirable to reflect the rights of a Participant with respect to a leave of absence subject to the FMLA, or similar state family or medical leave legislation that is not superseded by the FMLA.

PART V
HEALTH CARE SPENDING ACCOUNTS

5.01 Establishment of Accounts. The Company will establish and maintain a separate non-interest bearing Health Care Account for each Plan Year with respect to each Participant who elects to participate in the Health Care FSA Benefit Program. The Health Care Account will be maintained solely as a bookkeeping account used to reflect the amount allocated as contributions to and benefits received under the Health Care FSA Benefit Program for each Participant.

5.02 Crediting of Accounts. As of the beginning of the Plan Year (or, if later, the date a Participant's participation in the Health Care FSA Benefit Program begins), there shall be credited to a Participant's Health Care Account an amount equal to the Participant's Coverage Amount for the Plan Year (or the balance of the Plan Year). The Company will credit additional amounts into the Health Care Account of each Participant if the Participant or eligible Spouse or Dependent participates in and complies with the provisions of any Company-sponsored wellness programs designated by the Company. The additional credits are Company Contributions and the amount of the additional credits shall be determined by the Benefits Oversight Committee, or its delegate. The additional credits shall be communicated to Participants. Except as otherwise required by law, the amount credited to a Participant's account for each Plan Year shall be the property of the Company until paid out pursuant to Part VI of this Appendix B.

5.03 Debiting of Accounts. A Participant's Health Care Account shall be debited from time to time in the amount of any payment under Part VI of this Appendix B to or for the benefit of the Participant for Eligible Health Care Expenses incurred during the Plan Year.

5.04 Forfeiture of Accounts. The amount credited to a Participant's Health Care Account for any Plan Year shall be used only to reimburse the Participant for Eligible Health Care Expenses incurred during the Plan Year and while the Participant is covered under the Health Care FSA Benefit Program, provided the Participant applies for reimbursement on or before the Run-Out Period. If any balance remains in the Participant's Health Care Account after the Run-Out Period, the balance shall be forfeited by the Participant. The Company may, in its discretion, allocate forfeited account balances among Participants or use the amounts to offset Plan administrative costs.

PART VI
PAYMENT OF ELIGIBLE HEALTH CARE EXPENSES

6.01 Claims for Reimbursement. A Participant who incurs an Eligible Health Care Expense may apply to the Plan Administrator (or its designated claims administration representative) for reimbursement of the Eligible Health Care Expense. The application shall be

in the form as the Plan Administrator (or its designated claims administration representative) may prescribe. The application shall be accompanied by a written statement or invoice from an independent third party stating or indicating that the expense has been incurred and the amount of the expense. The Plan Administrator (or its designated claims administration representative) may also require as part of the application any other information or documentation as it may deem necessary or desirable to ascertain the eligibility of a Participant's Claim for reimbursement (*e.g.*, bills, receipts, canceled checks, explanation of benefits forms). Claims for reimbursement of Eligible Health Care Expenses must be submitted no later than the last day of the Run-Out Period or 90 days after the Participant ceases to participate in the Health Care FSA Benefit Program, if earlier.

6.02 Reimbursement or Payment of Expenses. A Participant shall be reimbursed for Eligible Health Care Expenses, in the time and manner as the Plan Administrator (or its designated claims administration representative) may prescribe, no less frequently than monthly. A Participant may only be reimbursed for Eligible Health Care Expenses incurred during the Plan Year or its related Grace Period while the Participant was covered under the Health Care FSA Benefit Program. The Plan Administrator (or its designated claims administration representative) may, as its option, or in accordance with the Participant's written direction, pay any Eligible Health Care Expenses directly to the person providing or supplying medical care in lieu of reimbursing the Participant.

6.03 Claims Procedure. The process by which a Claim for Benefits shall be handled by the Plan Administrator and the process by which a Participant may appeal the denial of a Claim for Benefits are described in the Summary Plan Descriptions and incorporated by reference.

6.04 Report(s) to Participants. The Plan Administrator shall provide to each Participant (or former Participant) who has received reimbursement of Eligible Health Care Expenses under this Health Care FSA Benefit Program during the Plan Year a written statement showing the amount of the assistance paid during the year with respect to the Participant (or former Participant). These reports must be provided at least annually, but may be provided more frequently.

6.05 Limitation on Reimbursements or Payments with Respect to Certain Participants. Notwithstanding any other provisions of this Health Care FSA Benefit Program, the Plan Administrator may limit the amounts reimbursed or paid for any Participant who is a highly compensated individual (as defined by the Code) to the extent the Plan Administrator deems the limitation to be necessary to assure compliance with any nondiscrimination provision of the Code. The limitation may be imposed whether or not it results in forfeiture under Section 5.04 of this Appendix B.

PART VII
QUALIFIED RESERVIST DISTRIBUTIONS

7.01 Qualified Reservist Distributions. The Plan will make Qualified Reservist Distributions to the extent that a Participant (or former Participant) requests a Qualified Reservist Distribution and demonstrates his or her membership in a reserve component (as defined in

section 101 of title 37, United States Code) to the Plan Administrator or its designee no later than the last day of the Grace Period for the Plan Year the individual is called to active duty. The amount of the Qualified Reservist Distribution shall be equal to the amount of the Participant's Benefit Contributions and Company Contributions pursuant to Section 5.02 made to the Health Care Account during the Plan Year that have not been applied to provide reimbursements of Eligible Health Care Expenses determined as of the Determination Date made in accordance with the Plan Administrator's policies and procedures. Qualified Reservist Distributions will be made without regard to Claims incurred and submitted but not yet reimbursed as of the Determination Date. Notwithstanding anything to the contrary, Participants who elect to receive a Qualified Reservist Distribution forfeit any right to reimbursement that would otherwise be available under the Health Care FSA Benefit Program. Participants who fail to elect a Qualified Reservist Distributions before the applicable Run-Out Period will forfeit any amount remaining in the Participant's Health Care Account.

PART VIII
MISCELLANEOUS

8.01 Funding Status of Health Care FSA Benefit Program. Except as may otherwise be required by law or under the terms of the Plan:

(a) Any amount by which a Participant's taxable compensation is reduced by reason of an election made under this Health Care FSA Benefit Program will remain part of the general assets of the Company,

(b) The benefits provided under the Health Care FSA Benefit Program will be paid solely from the general assets of the Company,

(c) Nothing under this Plan will be construed to require the Company or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and

(d) No Participant or other person shall have any Claim against, right to, or security or other interest in, any fund, account or asset of the Company from which any payment under the Health Care FSA Benefit Program may be made.

8.02 Assignment. The Participant may, if permitted by the Plan Administrator, authorize the Health Care FSA Benefit Program to pay a Participant's or Dependent's reimbursement directly to the service provider or hospital that provided the Participant or Dependent with covered care and treatment. Except as provided in the foregoing sentence, a Participant may not assign, alienate, anticipate or commute any payment related to any reimbursements or Eligible Health Care Expenses which a Participant is entitled to receive from the Health Care FSA Benefit Program and, further, except as may be prescribed by law, no benefits shall be subject to any attachments or garnishments of or for a Participant's or Dependent's debts or contracts, except for recovery of overpayments made by this Health Care FSA Benefit Program.

8.03 No Guarantee of Tax Consequence. Neither the Plan Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a

Participant under this Health Care FSA Benefit Program will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Health Care FSA Benefit Program, including a Qualified Reservist Distribution, is excludable from the Participant's gross income for Federal and state income tax purposes, and to notify the Company if the Participant has reason to believe that the payment is not so excludable.

8.04 Indemnification of Company by Participants. If any Participant receives one or more payments or reimbursements under this Plan that are not for Eligible Health Care Expenses, the Participant shall indemnify and reimburse the Company for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from the payments or reimbursements.

8.05 Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Health Care Expenses that have been substantiated by the Participant during the Plan Year or reimbursements have been made in error (*e.g.*, reimbursements were made for expenses incurred for the care of an individual who was not a Dependent), the Plan Administrator shall recoup the excess reimbursements in one or more of the following ways:

(a) the Plan Administrator shall give the Participant prompt written notice of any excess amount, and the Participant shall repay the amount of the excess to the Company within 60 days of receipt of the notification;

(b) the Plan Administrator may offset the excess reimbursement against any other Eligible Health Care Expenses submitted for reimbursement; or

(c) withhold the amounts from the Participant's pay (to the extent permitted under applicable law).

If the Plan Administrator is unable to recoup the excess reimbursement through the means set forth in (a) through (c), the Plan Administrator will notify the Company that the funds could not be recouped and the Company will treat the excess reimbursement as it would any other bad business debt. Similarly, if, it is determined that a Participant has received a Qualified Reservist Distribution for the applicable Plan Year in excess of the amount allowed by Section 7.01, the Plan Administrator shall give the Participant prompt written notice of any excess amount, and the Participant shall repay the excess to the Plan Administrator within 60 days of receipt of the notification.

8.06 Coordination of Benefits. This Health Care FSA Benefit Program is intended to pay benefits solely for otherwise unreimbursed medical expenses, except Qualified Reservist Distributions. Accordingly, it shall not be considered a group health plan for coordination of benefit purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

APPENDIX C
PARTICIPATING COMPANIES

HCA Management Services, L.P. and its Affiliates in which it owns a controlling interest

APPENDIX D
WELFARE BENEFITS

BENEFIT PROGRAM	FUNDING	CAFETERIA PLAN	CONTRIBUTIONS
Medical	Self-funded and Insured	Qualified Benefit	Pre-Tax
Dental	Self-funded and Insured	Qualified Benefit	Pre-Tax
Vision	Insured	Qualified Benefit	Pre-Tax
Basic Employee Life and Accidental Death and Dismemberment Insurance	Insured	Qualified Benefit	Company-Paid
Supplemental Employee Life and Accidental Death and Dismemberment Insurance	Insured	Qualified Benefit	Pre-Tax
Basic Spouse and Dependent Life and Accidental Death and Dismemberment Insurance	Insured	Not Qualified Benefit	After-Tax
Supplemental Spouse and Dependent Life and Accidental Death and Dismemberment Insurance	Insured	Not Qualified Benefit	After-Tax
Business Travel Accident Insurance	Insured	Qualified Benefit	Company-Paid
Short Term Disability	Insured	Qualified Benefit	After-Tax
Long Term Disability	Insured	Qualified Benefit	Before -Tax
Supplemental Income Protection	Insured	Not Qualified Benefit	After-Tax
Universal Life Insurance	Insured	Qualified Benefit	After-Tax
Health Care FSA	Self-funded	Qualified Benefit	Pre-Tax
Day Care FSA*	Employee pays all	Qualified Benefit	Pre-Tax
EAP	Insured	Qualified Benefit	Company-Paid

Long Term Care	Insured	Not Qualified Benefit	After-Tax
Health and Wellness Benefits	Self-funded	Qualified Benefit	Company-Paid
Prepaid Legal	Insured	Not Qualified Benefit	After-Tax
Automobile Insurance*	Insured	Not Qualified Benefit	After-Tax
Homeowners Insurance*	Insured	Not Qualified Benefit	After-Tax
Cash-Out Dollars for Waiving Medical Benefits	Self-funded	Not Qualified Benefit	Company-Paid
Cash-Out Dollars for Waiving Dental Benefits	Self-funded	Not Qualified Benefit	Company-Paid
Cash-Out Dollars for Waiving Basic Life and Accidental Death and Dismemberment Insurance	Self-funded	Not Qualified Benefit	Company-Paid

*These benefits are not ERISA benefits.

APPENDIX E
DESIGNATED EMPLOYEES WHO MAY RECEIVE PHI

- Benefits Department
- Positions within IT that must have access to PHI as part of job function
- Benefits Appeals Committee members
- Positions within legal department that must have access to PHI as part of job function
- Vendor Teams
- Plan Administrative Committee members